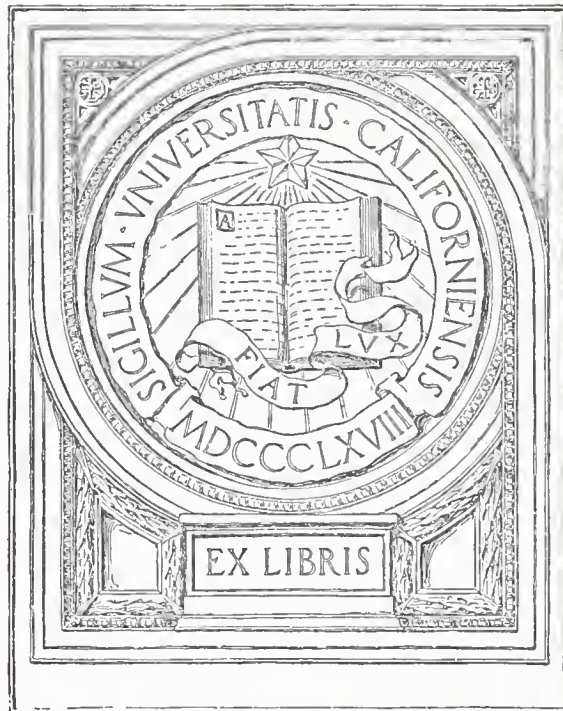




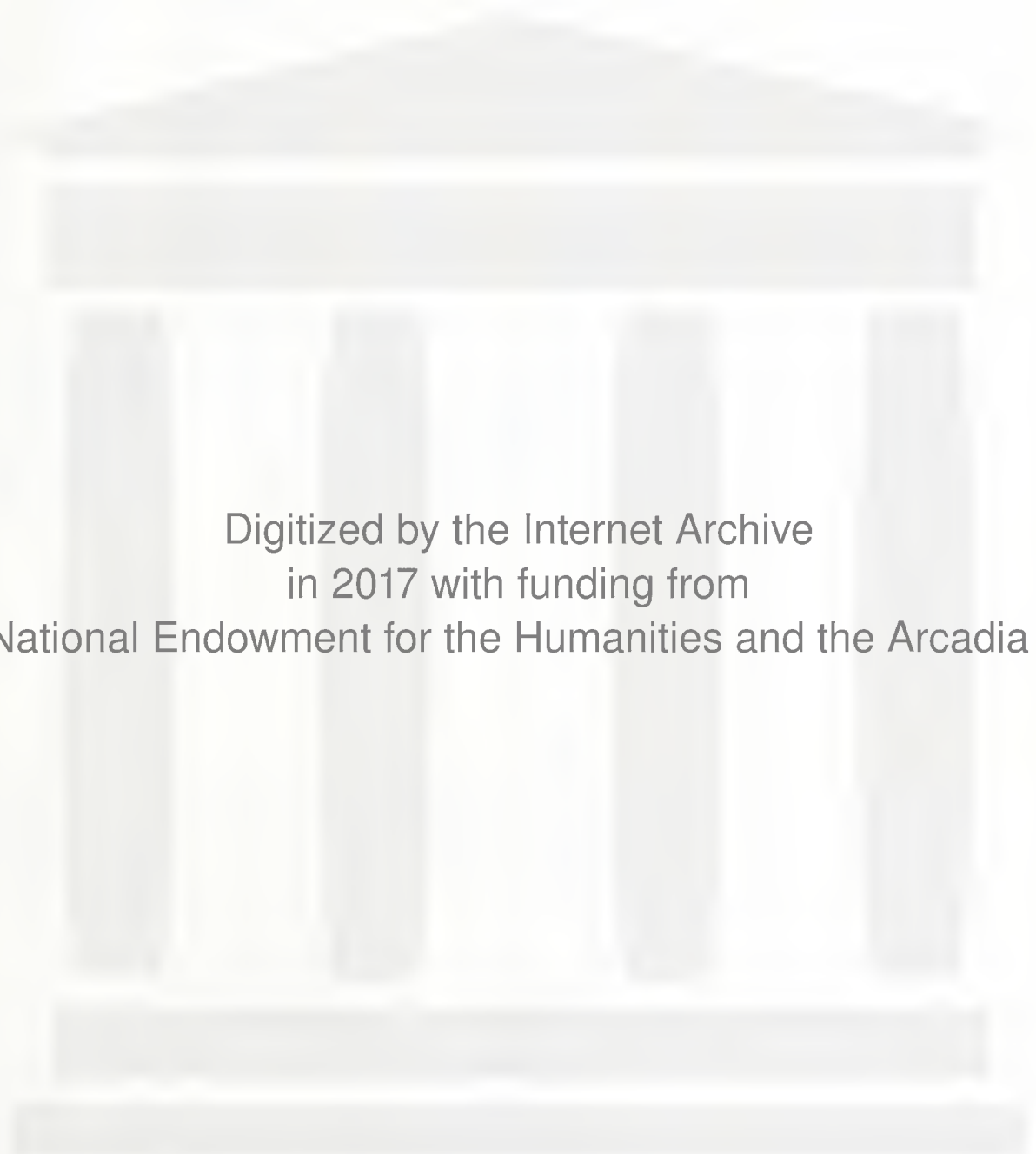
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# ALASKA MEDICINE

Volume 9, Number 1

March, 1967

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Smith Kline & French Laboratories 



# Alaska Medicine

Vol. 9, No. 1

March, 1967

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*Billy Sturdevant, young musher from Anchorage, works his dogs the final yards of the Iditarod Centennial Trail race. Sturdevant placed third in field of 60 racers.*

Anchorage Daily News Photo

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# LESTER HAROLD MARGETTS, Jr., M. D.

Born: Spokane, Washington — May 14, 1922

Died: Anchorage, Alaska — January 31, 1967

Surgeon, gentleman, friend, all these were Les Margetts, and much more. He was cheerful and straightforward in all his relations with life. We will not be blessed with his like again. He was gifted with remarkable calmness during moments of emergency, in surgery and in all facets of life. Actually, in time of vital emergency he was unusually good natured—more so than during the trivial irritations we all face day to day. In surgery this gift was well known to all his contemporaries; in regards to other occasions may I mention the following incident. It occurred one threatening, dark and brooding evening on our return from Ugashik. Lake Clark Pass was closed. Jack Jefford, pilot and mutual friend, decided we would try flying through Bruin Bay. Ceilings were low and the wind became more awesome and turbulent with each passing of jagged peak and storm gashed bay. Seat belts were tightened as to almost interrupt circulation and straps grasped until knuckles were white. The plane was tossed about as a bubble in freshly opened champagne. The wings now up, soon down, rarely level—stopped on each oscillation with a terrifying clump. Les remarked on this occasion, "Wouldn't you think a pilot of Jack's experience and ability could fly this ship without flapping the wings like a beheaded eagle."

Les Margetts was a staunch, easy fitting and enduring friend—brave, manly, honest, understanding, kind and learned. His death is a personal, profound loss to all who called him friend. He died too soon, at the zenith of his fine work, and in full possession of his unusual talents, doing his best work—a splendid, irreplaceable example for each of us. Had he lived longer, surely his gifts would have made him known beyond Alaska. He had many surgical firsts in Alaska and these were successful more because of his talents, courage and calmness than by reason of numbers of trained team members or white tower equipment.

He was not deeply opinionated—he had great respect for the views of others. His thoughts and his alone were not infallible—he could and did compromise. If his diagnosis was not correct or his treatment erroneous, he would frankly admit the mistake and did courageously strive to prevent a recurrence. A great and respected gift this, and one to be earnestly cultivated by each of us. Les was capable of open, bitter, and ample criti-



*Dr. Les Margetts*

cism of any who fostered injustice. He quarreled, but always wisely and never from pettiness or jealousy. In medical meetings he took a leading place, he was frank, forceful and literate in discussion, and the more he was stirred, the more logical, cold and biting were his remarks. He was devastatingly truthful in meetings as at all other times. The truth would out even when most unpalatable. No actor, facts to him were unalterable.

No thoughts of Les could be complete without mention of at least one of the innumerable personal incidents in my relations with this man I could so proudly call a friend. Shortly after Les arrived in Alaska, he and I were hunting ducks over on the Susitna flats. It was a warm day recently bright but now dulled to a pink haze in the evening sun. We chatted side by side on a gray, gritty, tide-tossed log—now stranded by the ebbing tide. A flight of low flying Mallards interrupted us, alas too late. They approached like a formation of Delta winged jets and as soon were overhead. Our shotguns followed and were discharged as the flight passed beyond our backs. No birds fell. Unbalanced, Les and I were still side by side but now half submerged in a gray volcanic and organic sludge. He commented: "Say! That air to ground stuff is potent today."

Carry on, Les — Friend, Man and Surgeon — until we who follow may also comprehend the secret of life which only death can reveal.



# GEORG WILHELM STELLER

## Physician-Naturalist on the Bering Expedition to Alaska

It is appropriate in this Centennial Year to commemorate a physician, Dr. G. W. Steller, who played a leading role in early exploration of Alaska. The following biographical sketch was written by an Alaskan physician who has spent a number of years in Western Alaska as PHS Service Unit Director at the Kanakanak and Bethel Hospitals. Dr. Fortune is the author of several other papers on the history of Arctic medicine.

By Robert Fortune, M. D.

Bethel, Alaska

"Good luck, thanks to my huntsman, placed in my hands a single specimen, of which I remember to have seen a likeness painted in lively colors and described in the newest account of birds and plants in the Carolinas . . . This bird proved to me that we were really in America."

By this happy feat of memory G. W. Steller, Adjunct in Natural Sciences and Physician on the Second Bering Expedition confirmed that he had indeed reached the western coast of the New World. The bird in his hands was *Cyanocitta stelleri*, now commonly known as Steller's jay, one that bears a certain resemblance to the eastern blue jay of the painting. The date was July 20, 1741, and the place Kayak Island, not far from the shimmering peak of Mt. St. Elias in Southeast Alaska.

Son of the village Cantor at Windsheim, Franconia, Georg Wilhelm Steller, or Stoeller as the family spelled the name, was born March 10, 1709. He attended the local Gymnasium where he graduated at the head of his class on Sept. 12, 1729, having excelled particularly in Latin. That same month he matriculated in theology at the University of Wittenberg, but he soon became impatient with the narrow limits imposed on his inquiring mind by the Deistic faculty. In April of 1731 he therefore transferred to the University of Halle, where, though still nominally in theology, he was able to satisfy a growing interest in the natural sciences, particularly botany. He attended lectures in anatomy and other medical sciences during the next few years but did not take a degree in this field. His unusual aptitude for botany, however, qualified him to hold a series of lectures as a *Privatdozent* as early as May, 1732.

At the suggestion of Prof. Friedrich Hoffmann, Steller went to Berlin in 1734 to appear before Prof. Ludolf of the *Obercollegium medicum* in the hope of finding a university position as a botanist. Though easily passing his examinations, he failed

to secure the position he wanted at Halle, because of the illness of King Friedrich Wilhelm, who had to approve individually all such appointments.

Hearing that the Russian Army to the east needed surgeons, Steller traveled to Danzig where he was immediately enlisted and assigned to an artillery regiment. Within a short time, he was put in charge of a Russian transport carrying wounded soldiers across the Baltic to St. Petersburg. After a stormy, thoroughly unpleasant passage, he arrived at the capital.

He soon met two very influential men, Johann Amman, the Professor of Botany at the newly established Academy of Sciences, and Archbishop Theophan Prokopovitch of Novogorod. The latter developed an immediate interest in the talented young man and took him into his household as a kind of protege, though Steller liked to think of himself more as a *Leibmedicus* to the prelate.

After several years of quiet study and botanical field work around the capital, Steller's interest was roused by a massive undertaking jointly sponsored by the Academy of Sciences and the Imperial Government—The Second Kamchatkan Expedition, which had departed in 1733 under the command of Vitus Bering to explore eastern Siberia and the surrounding waters. Steller foresaw the great opportunities for botanical research on this venture and used every persuasive means in his power to get an appointment. Finally in February, 1737, with Amman as sponsor and with the influence of the Archbishop, Steller was named "Adjunct in Natural History" at a salary of 660 rubles a year "including quarters, firewood and light."

In the fall he married a rich widow named Brigitta Messerschmidt, with whom he hoped to share his future adventures. They set out together in a troika in January, 1738, but by the time they reached Moscow, Brigitta had decided that the prospect of a Siberian winter did not have the appeal of the gay parlors of St. Petersburg. She accordingly left him and they never saw each other again. The pain of their separation did not last, however, for later, in Siberia, Steller was to write to his friend Gmelin, "I have entirely forgotten her and fallen in love with Nature."

The tedious journey across the expanse of Russia occupied more than two years. Steller became violently ill with a fever and nearly died



in Tomsk in the fall of 1738. After his recovery he pushed on to Yeniseisk where he spent seven weeks with the historian Gerhard Friedrich Mueller and the naturalist Johann Georg Gmelin, both of whom were about to terminate their participation in the expedition. Gmelin gave him a number of books for reference, among them the 1680 edition of Thomas Willis's *Opera Omnia*.

Steller moved on through Irkutsk to Yakutsk, where he arrived in May, 1740. Along the way he continued to make botanical observations and collect specimens. By August he was at Okhotsk, where he met Bering and learned that he was unable to join the projected sea expedition to the east. Therefore he took a ship to Kamchatka, arriving at Bolsheretsk in early October. Thwarted in his desire to accompany Bering, he sent a petition to the Academy asking permission to join Capt. Spangberg, who was about to make a return voyage to Japan. While awaiting a reply he spent the winter studying the natural history of the Kamchatkan peninsula. In February, 1741, however, all his plans suddenly changed when the Captain-Commander summoned him to Petropavlovsk for a conference.

Bering, who was a Russian naval officer of Danish birth, was making final preparations for a voyage by sea from Kamchatka to confirm possible reports of land to the eastward. His chief surgeon Caspar Feige had become too ill to make the journey, and remembering Steller's "reputation of being a skilled physician," Bering decided to invite the young botanist along instead. He saw in Steller in addition a chance to fulfil one of the major charges of the Senate, which had been to collect and study the minerals of any new territory. Steller, though he dearly wanted to accompany Bering, was in a difficult situation, since he had already committed himself to go to Japan if the Senate consented. When Bering himself insisted that he would take the entire responsibility, however, Steller signed on as a mineralogist to the expedition. In his unofficial duties as physician and naturalist, he was aided by Assistant Surgeon Betge and the draughtsman named Plenisher.

The two small ships, the *St. Peter* and *St. Paul*, set sail to the eastward from Avacha Bay on June 4, 1741. The larger of the vessels, the *St. Peter*, with a crew of 76 men, was under the personal command of Bering, while the second ship was commanded by Capt. Chirikov.

The Captain-Commander apparently took an immediate liking to Steller and shared his own cabin with him. The young naturalist did not fare

so well with the crew, however. Almost from the beginning, Steller made himself unpopular and even an object of ridicule among the officers and men. His arrogance and thinly veiled contempt for their abilities as seamen and navigators were hardly calculated to raise their respect and affection for one who had never been on a voyage in the open sea. To his journal, which he kept throughout the voyage, Steller often confided his bitter feelings:

"The brazen and very vulgar snubs by the officers, who coarsely and sneeringly rejected all well-founded and timely admonishings and propositions, thinking that they were still dealing with Cossacks and poor exiles freighting provisions . . . had been the cause of closing the mouth of myself as well as of others long ago."

On June 20, the two ships became separated during the night and after a futile search for several days, the *St. Peter* struck out on its own in a southerly direction.

On July 16 land was sighted shortly after noon bearing north by west at a distance of about 120 nautical miles. This landfall was the St. Elias Range, dominated by the great volcanic peak of that name. Steller recorded the event rather badly-naturedly in his diary:

"We saw land as early as July 15, but because I was the first to announce it and because forsooth it was not so distinct that a picture could be made of it, the announcement, as usual, was regarded as one of my peculiarities, yet on the following day, in very clear weather, it came into view in the same place."

This sulky mood soon passed off when he realized the tremendous meaning of the new discovery. Here was the culmination of years of waiting and working, a completely unexplored land doubtless filled with new plants and animals—an almost endless challenge to the young naturalist. On the 19th, an island Bering named St. Elias (now Kayak) came into view and the following day, after a search for a suitable landing, the *St. Peter* dropped anchor under the lee of the western cape.

Quite incomprehensible to Steller was the attitude of the Captain-Commander, who, as he says, "shrugged his shoulders while looking at the land." Bering was old, and the weight of his years had never felt heavier than now. After eight years of toil as leader of the Second Kamchatkan Expedition, Bering had come half way around the world over land and sea. His other ship was lost—maybe sunk—and even now the ship's fresh water was more than half gone. The season, moreover,



was late in these northern waters. Bering was a tired man, and though inwardly pleased at having reached his goal, his first thought was to return at the earliest moment to protect his ship, his men and his discovery.

Bering finally decided to send ashore a watering party led by Master Khitrov, Steller's worst enemy among the officers. At first he refused to permit the naturalist to accompany the longboat. In a fit of rage, Steller accused Bering of being interested only in "carrying American water to Asia" and threatened to report his conduct to the Senate and Admiralty "in the terms it deserved" upon their return. Such a public outburst to the captain's face might have cost Steller his freedom or even his life, but Bering, who was probably more amused than offended by the outburst, finally consented to let Steller go, to fulfil one part in his own instructions, namely, to investigate the mineral resources of the region. He furthermore gave the Adjunct a little send-off from the rail by a flourish from his two trumpeters. That Steller was a little uncertain of how to take this display is shown by a note in his diary:

"Without hesitation I accepted the affair in the spirit in which it was ordered, as I have never been a braggart, nor would I care for such attentions even if they were really intended to honor me."

Once ashore, Steller's whole demeanor changed. Knowing that time was precious, he set about accomplishing as much as humanly possible. On the beach he found a hollowed log in which humans had cooked a meal with hot stones. Caribou bones were found nearby, along with mussels and bits of dried fish. Rushing inland with his Cossack, he discovered a native dwelling, a pit 12 feet deep covered by tree bark on poles, in which were utensils, sweet grass, thongs of seaweed and arrows. About an hour later he received an urgent message that if he did not return immediately to the beach, he would be left behind. Instead he sent his Cossack off to shoot birds while he himself walked to the westward, returning at sunset. After another warning, he finally returned to the ship where to his great astonishment he was treated to chocolate by Bering in his cabin. He had been on Kayak Island for 10 hours, during which time he had seen positive signs of human occupancy and discovered many new plants and animals, among them the Alaska salmonberry and the Steller's jay already mentioned.

The following morning at daybreak, Bering took advantage of favorable winds to leave before all the water casks were filled.

On August 2, the ship was close to a foggy island now called Chirikov I, in honor of the captain of the **St. Paul**. Another struggle ensued between Steller and the Captain-Commander about going ashore, but this time no landing was made. On the 4th, a group of islands (The Semidis) was spotted, the waters of which abounded in fur seals, sea lions and sea otters.

On August 10, Assistant Surgeon Betge had a conference with the officers at which he reported 21 cases of scurvy among the crew, including five persons unfit for duty. Another council of officers was held Aug. 27 to consider the low water supply and the sickness of the men. A group of islands was sighted Aug. 29 and immediately preparations were made to go ashore. This time Steller found himself asked to accompany the party, as he notes in his diary, though characteristically he suspected that the officers wanted to share in the discoveries he expected to make. The sailors almost immediately began to fill the casks from a brackish pool, although Steller found several good springs. He insisted that the bad water would only worsen the scurvy and that its salinity would increase with age, even sending a sample of his spring water back to the ship. "But," he wrote, "although in this matter I ought to have been listened to in my capacity of physician, nevertheless my proposition . . . was rejected from the old habit of contradicting."

Nikolai Shumagin, a seaman, died August 31, the first victim of scurvy. He was buried ashore, giving his name to the island (now Nagai) and later to the group.

Steller, becoming increasingly exasperated by the turn of events, felt thwarted on all sides. He had been forced more and more into the medical duties yet found no support or resources for the task. ". . . I had made representations," he wrote in his journal, "that our medicine chest, from the very beginning, had been miserably supplied, inasmuch as it was mostly filled with plasters, ointment, oils and other surgical remedies enough for four to five hundred men in case of a battle, but had none whatever of the medicines most needed on sea voyages and serviceable against scurvy and asthma, our commonest cases; . . ." He asked for a detail of men to help him collect antiscorbutic herbs ashore but the request was not granted, though later, he recalled, when there were only a few able-bodied men remaining on board, "I was tearfully begged to help and assist, which then, though with empty hands, I did to the utmost of my strength and means . . ." His real and imagined wrongs finally led to an



unworthy resolve: ". . . when I saw my opinion concerning the water again spurned and coarsely contradicted and had to hear myself, like a surgeon's apprentice belonging to the command, ordered to gather the herbs, and that this important work, which affected the health and lives of all, was not considered worth the labor of a few sailors, I repented of my good intentions and resolved that in the future I would only look after the preservation of my own self without wasting another word."

These bitter reflections were interrupted on Sept. 5 by the appearance of natives for the first time. The ship had finished watering and had attempted unsuccessfully to depart, but because of adverse winds it had had to heave to and anchor off the north end of Bird Island. Two natives, in small skin boats not unlike those of the Greenlanders, paddled to the ship and exchanged trinkets with the crew. After some attempt at communication, Steller, Lt. Waxell and others rowed ashore with them but were unable to land their boat because of the rocks and surf. Instead, several went ashore in the water and were well received by the natives who gave them whale blubber as a token of friendship. The brandy offered in return was spat out in disgust. When the sailors finally attempted to return to the boat, the natives misunderstood their actions and prevented them from leaving until a shot was fired over their heads, whereupon they fell down as if dead.

These aboriginal inhabitants of the Aleutians were described by Steller as medium in stature, plump, well-proportioned and with black eyes, glossy straight black hair and flat noses.

The **St. Peter** got under way the next day, plodding southward for a few days, then veering westward again. Day by day new cases of scurvy appeared. Bering himself became so sick that he entirely lost the use of his limbs. Steller, however, despite his earlier threats, administered some of his personal supply of spoonwort, collected at Nagai, to the Captain-Commander, with the result that within eight days he was able to go on deck again.

Beginning Sept. 25, a severe storm arose, pounding the little ship with whistling winds and mountainous seas for more than two weeks. By this time over twenty persons were incapacitated by sickness, leaving barely enough crew to manage the ship. For most of the storm the little vessel wallowed out of control. "There was much praying," observed Steller wryly, "but the curses

piled up during ten years in Siberia prevented any response."

By mid-October, 29 men were on the sick list. Lt. Waxell, second in command, tried to convince Bering, who himself was still badly laid up with the scurvy, that the ship should winter in America but the old man grimly decided to push on. Morale was at a very low ebb indeed. Steller confided to his journal "misery and death suddenly got the upper hand on our ship . . . The small allowance of water, the lack of biscuits and brandy, the cold, dampness, nakedness, vermin, fright, and terror were not the least important causes." On Oct. 25 they sighted an island, probably Kiska, and considered going ashore for water, but it was conceded that the crew was too weak to weigh the anchor once it had been dropped. By Nov. 3, there were so many sick that it was scarcely possible to make any changes in the sails.

On Nov. 5, land was sighted again, this time a small island, followed shortly by a larger one, in what is now known as the Commander Group. A council of the officers was held. Bering, who was very weak, aroused himself with some excitement and talked optimistically of an early release for all from the miseries of the voyage. He felt that they were so close to Kamchatka now that it would be foolish not to go on. Only one officer agreed. With 12 men already dead and 34 totally disabled for duty, and with only six casks of bad water remaining, the consensus was to spend the winter ashore rather than to take a chance on the open sea again. At last Steller was invited to speak. The former slights still rankled: "I have never been consulted in anything from the beginning, nor will my advice be taken if it does not agree with what is wanted; besides the gentlemen themselves say that I am not a sailor; therefore, I would rather not say anything." His journal continued: "I was next asked if I, as a person worthy of belief (being now for the first time so considered) would not at least add a written certificate regarding the sickness and the miserable condition of the crew.—This I therefore undertook to do, in accord with my conscience."

Finally, on November 6, the resolve to stay was firmly taken and the anchor dropped into the waters of the natural harbor. Steller went ashore the next day, along with a number of the sickest members of the crew. Bering himself, in critical condition, was brought ashore two days later. The next few weeks were spent in unloading the ship and making preparations for the "winter" which was already close upon the wretched band. Many



died as they were brought into the fresh air to come ashore, no fewer than four on one day. "Some of the sick," Steller relates, "cried because they were cold, others because hungry and thirsty, since the mouths of many were so miserably affected by the scurvy that they could not eat anything because of the great pain, as the gums were swollen like a sponge, brown black, grown over the teeth and covering them."

Fresh food now was abundant, although it was difficult to find the strength to obtain it. Ptarmigan, sea birds, and sea mammals were plentiful. Steller caught a sea otter on the 12th, which he tried to share with Bering, but the old man preferred ptarmigan and would not touch it. The last of the sick were brought on shore November 15.

Steller built a shelter for himself, Plenisher, the draughtsman, Betge and several others. Master Khitrov, himself ill with scurvy, asked to be taken in but Steller refused since his old enemy was "mostly sick from laziness and was the chief author of our misfortunes." Lt. Waxell, on the other hand, Steller tried his utmost to preserve for fear that otherwise Khitrov might succeed to the command.

On November 28, a gale drove the ship ashore, destroying at last any hope of reaching home that year. It was a sorry group huddled together in the damp, raw wind, exhausted, almost naked and plagued by illness and despair.

Blue foxes were everywhere. They had no fear of man, nibbling on toes, eating provisions, and chewing on corpses. Steller himself killed over 200 of them and seemed to take a cruel pleasure with the others in torturing them. "Some," he said, "were singed, others flogged to death . . . It is most ludicrous when, being held by the tail they pull with all their might and someone then cuts off the tail . . . Nevertheless they could not be warned."

The Captain-Commander died early in the morning of December 8. Steller was perhaps more touched than anyone at the passing of the old gentleman, who, he said "perished rather from hunger, cold, thirst, vermin and grief than from any disease." To which in his diary he appended a rather tedious account of his agonal pathological state. The young scientist recognized clearly the debt he owed him. "The only blame," Steller remarked, "which can be laid against this excellent man is that by his too lenient command he did as much harm as his subordinates by their too impetuous and often thoughtless action." Bering

was buried under a simple cross on the hillside and his men named in his honor the island which claimed his remains.

Steller's true talents were belatedly recognized by the crew, once they could see his inordinate skill in making the best of the situation in which they all found themselves. They looked to him for help in building a shelter, finding water and killing game for food. Once off the ship and especially after Bering's death, many looked on him as their leader, though Lt. Waxell had officially succeeded to the command.

Nor were Steller's efforts wholly directed toward subsistence. He took a lively interest in the island and its unique natural history, taking voluminous and precise notes, later published, on the climate, plants, birds, mammals and fish. Sea mammals held his attention especially. While on the island, he described no less than four such animals new to science. Two of these, the sea otter and the northern fur seal, were to have a tremendous economic importance for the Russians in the New World. Two more have been given the name of the scientist himself—the Steller sea-lion and the Steller sea-cow. The latter was a unique animal which became extinct by wanton slaughter a mere 27 years after its discovery. A number of these creatures were harpooned for food and one weighing an estimated 8,800 pounds and measuring over 24 feet in length was dissected and described by Steller, the sole scientific record of the species. His notes on sea mammals were published after his death under the title *De bestiis marinis* (1751). His observations on birds produced at least two more new to science in addition to the jay—the spectacled cormorant, now extinct, and the beautiful little Steller's eider.

His botanical discoveries are more difficult to appreciate today, since his descriptions antedated the binomial system and classification propounded by Linnaeus only a few years later. Steller made an extensive list of the plants found on the island, as well as collecting numerous specimens, some of which later reached St. Petersburg.

In April a council of officers was held to determine the best course of action to be taken. It was decided to break up the **St. Peter**, and rebuild a much smaller vessel, in which they would attempt to reach the coast of Kamchatka. With the unfolding of spring, spirits and hopes freshened considerably. Several of the men had only now fully recovered from scurvy when given fresh greens collected by Steller.



On the 5th of May, the sternpost was erected of the "Hooker St. Peter." After work into the summer, all was at last in readiness for the launching, which took place on August 10, 1742. Three days later the little craft with 45 survivors set sail for the west, arriving at the harbor of Petropavlovsk on the 27th of August.

Steller's subsequent life may be briefly told. The following two years he worked out of Bolsheretsk exporing, writing and botanizing, and even making a trip to the Kurile Islands, while waiting for news from St. Petersburg. The expedition was officially disbanded by an Imperial Ukase of Sept. 23, 1743. Steller later received his orders from the Academy of Sciences to return to St. Petersburg via Yakutsk, Tomsk, and then down Irtysh River to Tobolsk, with special attention to describing the fish and plants on the way.

In the spring of 1744, while still at Bolsheretsk, Steller quarreled with a midshipman named Khmetevski, who, with the departure of Lt. Waxell, had become the ranking naval authority over the remainder of the expedition. Both men sent versions of their charges to the Governing Senate, Steller being accused of releasing without authority some Kamchadal rebels.

With sixteen packing cases of manuscripts and specimens, Steller finally left Kamchatka for Okhotsk by ship, on Aug. 3, 1744, and by October had reached Yakutsk, where he spent the winter. By the fall of 1745 he had reached Irkutsk. At this city he faced the charges brought against him by Khmetevski and was duly acquitted by the Vice Governor. Through an unfortunate delay, however, the news was not promptly forwarded to the capital, with the result that the following year, which found him far to the westward in the Ural Mountains, he was arrested by an Imperial emissary as an apparent fugitive from justice. Despite his bitter protests, Steller was accordingly escorted toward Irkutsk, to stand trial again. On the way, east of Tobolsk, another messenger caught up with the party with orders for Steller's release. He remained in Tobolsk for about three weeks, drinking heavily, and then set off to the westward once more against the advice of his friends. Burning with fever, he reached Tyumen, where despite the care of the Surgeon Lau of the **St. Paul**, who by an extraordinary coincidence happened to be in the town, he died on November 12, 1746, at the age of 37. He was buried just outside of town, overlooking the river.

Steller's place in history remains secure on the basis of his work as a botanist and zoologist in

Siberia, Kamchatka, Alaska, and above all Bering Island. The sea mammals of the northern Pacific will always be associated with his name. Linnaeus, the great Swedish botanist and systematist, called him "a born collector of plants" and in a letter to Gmelin urged the latter to adopt the genus name **Stelleria**, since "Everyone in the botanical world who knows plants loves Mr. Steller."

Unfortunately, as the record shows, Steller the man was not so lovable. He could be vain, arrogant, cruel, ambitious, selfish, and short-tempered. An intense, humorless man, he was impatient with anyone who stood in his way. This desire for success made him a good scientist but a bad companion, and indeed, Steller did his best scientific work alone under field conditions. For a man of his temperament and education, a long sea voyage under cramped conditions and among coarse unlettered seamen was bound to bring out the worst in his nature. It is unfortunate in this regard that most of the personal records that remain of Steller's views and attitudes are taken from his own diaries and other recollections of the Bering Expedition, where life was full of hardships and frustrations.

Perhaps they give a slanted view, since in his earlier life many prominent men of learning had sought his friendship. His positive qualities also became apparent during the long sojourn on Bering Island, where his skill, courage and resourcefulness may have salvaged the expedition from total destruction. Bering himself of course recognized Steller's ability and was willing to overlook his impetuosity and pettiness. So did Lt. Waxell, who having seen him at his best and worst, called him years after the expedition "a great botanist and anatomist, well versed in natural science."

Steller died tragically in the prime of life. His name, however, will perhaps always be linked with that of Bering and associated with the unique plants and animals of the North Pacific region.

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# MEDICAL ACTIVITY—ST. MARY'S MISSION

St. Mary's Mission is a school on the Andriefski River, first left turn off the Yukon going down from Pilot Station. There are over 200 students, mostly eskimo, with about 130 boarders from the lower Yukon and Kuskokwim and another 100 day students from the immediate area. Medical activity includes giving care for the Mission boarders and personnel numbering about 160, St. Mary's Village with a population of 285, Pitka's Point around a 6-mile corner on the Yukon with a population of 50 and people living at points between totaling about 35. The nearest hospital and doctor are 100 miles south at Bethel, reached only by plane and contacted only by radio. Medical personnel include a medical aide elected by the village council and a registered nurse who volunteered as school nurse for St. Mary's Mission School.

**By Adelaide A. Wiley, R. N.**

BSN '62 Georgetown U. School of Nursing  
**Present Mission Nurse**

A look at the mission clinic's log gives some idea of the medical activity at St. Mary's. Glancing through we see that the number of patients visiting the clinic daily runs about 25. The week averaging 75 visits a day represents a flu epidemic with patients lined up into the hall waiting to have their temperatures taken with only 30 thermometers and whole dorms turned into infirmaries. Eight clinic visits represent a holiday.

Included in these visits are a few students with headaches, a girl with dysmenorrhea, a squint-eyed basketball player holding the remains of a pair of glasses, an alert first grader with sores that require cleaning, and an exhausted girl with a hacking cough. Frequently a youngster comes in with nausea and vomiting or diarrhea. A stomach ache along with this raises the question—is it or isn't it? Appendicitis that is. Once appendicitis was occurring in "epidemic" proportions with two students sent to the hospital and operated on in five days. And this in the middle of a very real intestinal "flu" epidemic. Then there are the daily visits of a 7th grader with a history of draining ears for the last seven years. Occasionally a brave little girl is at the door fighting back the tears as she holds onto her ear for all she's worth. Or a second grade boy is sent up as he isn't concentrating in class due to a rotten tooth. A stream of cuts and burns come in from the kitchen and bakery area. Basketball days bring in a fair number of abrasions. And with 60 boys in the dorm, a few black eyes are seen. Naturally these are all acquired from running into the door. And being in the climate it is, the log also records a few cases of frostbite.

Sprinkled throughout the log are more serious problems. Pneumonias turn up pretty frequently. Recorded here and there are fractured collar-bones, severe dog bites, and injuries resulting from ski-dos and sleds tipping over. As most of the fuel in the area for heat and cooking is wood, axe injuries are not uncommon.

Treatments as recorded show that pHisohex scrubs and DSD take care of most things. Butterflies take the place of stitches. Tongue blades splint fingers and wrists and broom sticks handle anything bigger. Soaks have their place being used for sprained ankles, burns, frostbite, injured fingers, puncture wounds, cellulitis, preliminary treatment for scrubbing up areas of impetigo, sore eyes, sitz baths, infected wounds, and dermatitis. One day on record there are nine soaks. What the record does not tell is that seven of these had to be done at the same time in a clinic where three is a crowd, with regular clinic traffic coming and going. Hot water bottles are passed out at night for tooth aches, ear aches, back aches, and chest pain. Ice packs are prepared as needed for head injuries, sprains, acute abdomens and nose bleeds.

On the medicine shelf is found aspirin. Last year 15,000 were given out. Metimyd is the stand-by eye ointment. All that is red is not PKC, but up here the odds are for it. Bacitracin is used on infections, desenex on feet. Penicillin treats most of the pneumonias, acute ear infections, sore throats, cellulitis, and wound infections. Penicillin is also used prophylactically for a few with histories of rheumatic fever and one with Henoch-Schoenlein syndrome. Benadryl is the stand-by for allergies and hives which show up rather frequently. Gelusil does wonders for stomach aches occurring about exam time or just before a speech class. Other medicine is used, but not as frequently.

Not in the log, but possibly given out in bigger doses than anything else is TLC. No boarding school can escape a few cases of homesickness or loneliness. And there are the younger students who come in physically hurt it is true, but whose pride is hurt more, as not only were they whacked on the head by a broom, it was their best friend that did it! Or possibly the fall that cut up their shins "let that guy get away when I was just close." From the older students comes a knock on the door and a request for aspirin, but what might be needed more is a good ear.



Lab work at present is limited. Combi-stix, hemo-stix, and a Hgb-Meter accounts for most of it. An occasional WBC is done on someone with an acute abdomen when there's an anticipated wait of 12 hours before a doctor or plane can be contacted. Sputums are sent to labs in Anchorage for AFB. An occasional slide and blood sample are sent to Bethel Hospital. Once Bethel Hospital was the recipient of one well wrapped dog's head.

On the margin of the pages in the log are found such notes as 3 pairs glasses sent for repairs, 4 sputum cans sent in, drug order sent, 2 begging letters written, received donation of vitamins, or letter to doctor regarding 5 patients. Or such notes as 20 Snellen screening tests and 15 audiograms done might be found. 33% of the students have a hearing loss in one or both ears greater than 30 decibels and most of these have a history of draining ears. Or there might be notes like grade school weighed, student records brought up to date, or clinic cleaned.

Sometimes as often as five times a week or even three times a day are found names listed with village and a number written after it. These represent the home visits and the time spent there. The time may be 1 hour, 2 hours, and once 10 hours. This last was a call from Mt. Village. The record does not tell that this includes travel time which is by kicker boat or sled depending on the season, feet if no other transportation available for the call one mile and more away and naturally for the calls in the village proper.

And as frequently there are notes regarding medical traffic—3½ hour stand-by with two patients reported, or radio medical traffic 3 hours stand-by, no contact as poor reception. Sometimes this last note occurs day after day once week after week. Not recorded is the winter temperatures of the radio room which are sometimes 38°F at head level and below freezing at foot level.

Now and again it is recorded that a doctor is here. This may be the regular annual field trip of a doctor from Bethel Hospital with a 4-day stay or a doctor from Arctic Health on a research project requiring a two-day stay. Or possibly it's Doctor Fritz from Anchorage who last year in 4 days prescribed 92 glasses for 94 students seen out of an enrollment of 224, some of these already having glasses and leaving 42 students not seen for lack of time. Dr. Carpenter's annual two-week stay working on teeth is duly recorded. Once a field chest clinic was held here. And once a doctor was stranded—a gift from heaven.

Once a year the record shows the x-ray team

came. Often it is noted that a nurse is visiting. This may be the Alaska Department of Health's itinerant nurse on her field trip or an Arctic Health nurse working on a special project. Or it might be the mission's traveling nurses in between trips. Working from the mission these nurses go as a pair to the neighboring villages for visits lasting up to two weeks. Once there they teach catechism and modified medical self-help to the villagers. Much of their time is spent visiting which gives an opportunity to do health teaching on a one to one basis which has been found to give the best results. While in a village they are often consulted on particular health problems occurring during their stay.

Also on record are patients going and coming from the hospital. One day six were flown out to the hospital—a boy with psychotic-like symptoms, a child with dog bites from a possible rabid dog, two villagers found to have active TB, one woman with a threatened miscarriage, and a 4th grader with partial facial paralysis and a long history of draining ears. Just six days later three more villagers went out with active TB, a mother with a history of previous complications to await delivery near a hospital, a baby with pneumonia, and a woman with severe headaches.

Over several periods of time notes appear that medical classes were held for the village medical aides or that Medical Self-Help was taught to the freshmen.

This is all work involving the mission nurse, some of it more completely than others. In regards to the villagers the mission nurse works with the village medical-aide, seeing only those patients about which the medical aide asks advice or referring someone to the medical aide when medical assistance is indicated. When the nurse does see villagers or goes on sick calls in the village she tries to teach the medical aide so that the next time the medical aide will be able to go ahead and handle a similar situation herself. Specifically in regards to OB patients, the nurse works with the village midwife, again trying to teach as the occasion arises. It is a situation where the midwife has the experience, the nurse the book knowledge and hopefully a mother with a command of English and Eskimo. In the last year there are records of five home deliveries and most of the mothers go to the hospital. One delivery on record has a notation that the placenta was retained for seven hours. Off the record it took 84 miles of kicker rides making seven round trips between patient and radio to get the situation taken care

of. Another delivery required crossing a slough during break-up in the dark to get there. In this area, with regards to the OB patients, an ounce of prevention is worth a ton of cure. So once a month a note is found in the log—Pre-natal clinic held—five, six or possibly even 12 seen. The number depends on the time of year.

In regards to visits by others in the medical profession the mission nurse helps as needed as prescreening in anticipation of the eye doctor's visit, sending for needed people, keeping track of the census for both mission, village, and surrounding area especially for the x-ray team and immunization programs to get as close to 100% participation as possible. Or the mission nurse may help give the immunizations. In preparation for the dentist's visit she gets the dental clinic, which serves as a storeroom in between times, cleared and scrubbed.

Specifically regarding the mission students and personnel, the mission nurse takes full charge of those sick giving all treatments, medicines, and nursing care as ordered or indicated. This involves carrying food trays, preparing hot water bottles and ice packs, packing water, many a watchful night, and very often a lot of foot work. Also volumes of paper work are involved—

getting records, keeping them up to date, filing, drug orders, letters to doctors. Attempts are made to keep the necessary medical supplies in stock. This is done by begging, borrowing, but as yet no stealing. And there is always the clinic itself to be kept clean and in order along with the equipment in it.

A bright spot on the mission nurse's calendar is the return of the mission's traveling nurses. With their return the work is divided. Without their help the mission activity might not be as great as it is now recorded in the mission clinic's log.

**BACKGROUND ON ADELAIDE WILEY, R. N.**

Now 26 years old and in her third year as a volunteer nurse at St. Mary's Mission, Miss Wiley is a graduate of Georgetown School of Nursing, Washington, D.C. Her father, John Preston Wiley, is an officer in the State Department. Prior to her work at St. Mary's Miss Wiley was a \$6,000-a-year nurse at U.S.P.H.S. Hospitals in Kotzebue and Mt. Edgecumbe. For her work at St. Mary's she receives room and board and the right to draw on the Mission store for stamps and stationery. During the summer of 1965 she conducted medical aid courses for adults in the villages of Stebbins and St. Michael on the Yukon delta. On her rare visits to Anchorage, Miss Wiley rates a big hamburger and hot fudge sundae as major attractions.

**Hotel reservations for your stay in Sitka during the Annual Meeting, June 7-10, 1967, should be made as soon as possible. Pat Sarvela, Dr. T. M. Moore's office nurse, has volunteered to help with this vital task. Write now for your reservations:  
Pat Sarvela, R. N., Box 1000, Sitka, Alaska.**



# Muktuk Morsels

Anchorage Medical News has been overshadowed by the sudden and untimely death of **Dr. Les Margetts**. In his 12 years of active surgical practice in Anchorage Les had become a loved and respected community figure.

**Dr. William Mills** was awarded the Bronze Star for bravery in the diagnosis and treatment of a South Vietnamese marine with a huge subcutaneous mass of recent onset. Because of his language problem, the patient kept thumping the mass, which absorbed Bill's attention completely when he discovered that it was a live mortar shell. Apparently on his way to South Vietnam for a six month tour is **Dr. Alan Homay**. We expect more information shortly. **Dr. Marcell Jackson** has resigned from the Doctors Clinic and has taken over Dr. Homay's practice.

**Dr. Donald R. Rogers** of Seattle, a board qualified pathologist, has joined the Doctors Clinic in Anchorage. **Dr. Merritt Starr** has taken over the State Medical Society T-V program series. **Dr. Elizabeth Tower** has resigned as Editor-in-chief of Alaska Medicine after many productive years of labor on the editorial rock pile. The many duties that she so ably performed will be divided between the new editor and **Mr. Bob Ogden**. Mr. Ogden is the new Alaska State Medical Society executive secretary. He was most recently the business manager of the Juneau Clinic and chairman of the Juneau Hospital Committee.

**Dr. Grace Jansen** recently was married to Vin Hoeman, a well known American mountaineer whose ideas of comfort are off by about 100 degrees (fahrenheit). **Dr. Bruce Wright** recently married Nancy Allison of Anchorage. **Drs. Fred Hillman** and **Louise Ormond Hillman** have adopted an infant son. **Dr. Richard Paul** had his second son (third child) and **Dr. Paul Dittrich** recently had his first child, a boy.

We hear that **Drs. Robert** and **Helen Whaley** are reserving their decision on returning to Anchorage pending clarification of medical liability issues and legislation. Many Alaskan physicians share their doubts on continuing medical practice in Alaska under present circumstances.

As February ends **Dr. George Wichman** is reported above 17,000 feet with a group of mountaineers making the first winter ascent ever attempted of Mt. McKinley. We will have more on this later.

**Dr. Harold Bartko** has gone to Nome from Anchorage and will work at the Maynard McDougall Memorial Hospital. At present he is the only physician in Nome. He was recently appointed to the Alaska State Health Facilities Advisory Council by Governor Hickel.

From Seldovia we learn of the recent death of Mrs. Florence Armstrong. **Dr. O. H. Armstrong** is reported out of the state at present. **Dr. John Fenger** of Homer is taking a two-year residency in Physical Medicine and Rehabilitation at the University of Washington. (P. O. Box 758, Bothell, Washington). **Dr. Joseph Deisher** visited Seward in December and then returned to the Marshall Islands for the last months of his tour there. Dr. Deisher plans to take a fellowship at the University of Illinois in Continuing Medical Education as preparation for a position as Director of Medical Education.

**Dr. Bob Johnson** of Kodiak was appointed to the Alaska Board of Basic Sciences. **Dr. David Sammann** left Skagway in December for graduate work at the University of Washington. He expects to return in April.

**Dr. Joseph Rude** has retired from the Doctors Clinic in Juneau. His son, **Dr. Donald Rude**, passed his Boards in surgery and is now practicing in Swahili at the Lutheran Hospital, Kiomboi, Tanzania, Africa.

**Dr. John Beeson** (Alaska Medical License #20, 1916) who practiced in Anchorage many years as the chief surgeon of The Alaska Railroad, before moving to Ketchikan, is hale, hearty and retired in La Jolla at age 94. In 1933 Dr. Beeson moved to Wooster, Ohio and founded a medical clinic there, staffed originally with his two sons; **Dr. Harold Beeson**, a former Anchorage Times reporter and now Assistant Medical Director for the Department of State in Washington, and **Dr. Paul Beeson**, now the Nuffield Professor of Medicine at Oxford University in England.

**Dr. Henry Wilde**, formerly of Juneau, is now regional health officer for the Foreign Service Diplomatic Corps in Guinea, Senegal and Mauritania. Dr. Wilde is stationed in Conakry, Guinea.

With the advent of the new Republican administration **Dr. Levi Browning** has been replaced as Commissioner of Health and Welfare by **Dr. Wallace J. Chapman**. Dr. Chapman was in general practice in Cordova for five years with his wife



**Dr. Jean Chapman.** He then worked for one year in California before returning to his present post in Alaska at Governor Hickel's request. Dr. Browning is presently vacationing at his Palmer homestead. Also in Juneau **Dr. Jack Lesh** has been replaced by **Dr. D. V. Reddy** as Director of Maternal and Child Health and Crippled Children's Services. Dr. Reddy is originally from Hyderabad, India. He trained in pediatric cardiology in Cleveland and California, and got his M.P.H. in California. With his public health background, and as a board certified pediatrician and a board qualified pediatric cardiologist, Dr. Reddy has a rare combination of skills greatly needed in Alaska. In his new position as medical consultant for the Department of Welfare Dr. Lesh will have more time for his Gus Davis Inn project near Glacier Bay.

**Dr. Grace Field** has retired after many years as Clinical Director for the Veterans Administration in Alaska. Her warmth and genuine interest will be missed. Dr. Field plans to live in Juneau. Her position has been filled by **Dr. Richard D. Kraft** of Virginia.

From Ketchikan we hear that **Dr. Donald Wadsworth** has moved to Bend, Oregon.

**Dr. Donald Tatum** recently returned to Fairbanks for four weeks, unfortunately as defendant in a malpractice suit **Johnson vs Tatum**. Dr. Tatum is a board certified internist who practiced seven years in Fairbanks. He now resides in Portland, Oregon where he specializes in allergy. Several weeks ago the jury brought in a verdict against Dr. Tatum of \$300,000, which is twice the limit of his insurance liability (Lloyds). A brief summary of the case should be of interest to all Alaskan physicians. On June 30, 1962 Mr. Johnson, age approximately 50, was admitted to St. Joseph's Hospital with a "stroke". Past history, as obtained later, showed that he also had a possible transient stroke in 1960, a definite myocardial infarction before 1959, a history of some years of hypertension with recent return to normotensive levels on no medications, an elevated cholesterol (304) and a heavy smoking history. During his hospitalization Mr. Johnson was intermittently uncooperative, confused, and sedated. On about the eighth day in the hospital he developed leg pain which initially required Codeine every 12 hours but later required frequent doses of Demerol for control. Because of a discolored area on the leg anterolaterally and a tender thrombosed vein on the foot he was initially treated for phlebitis with heat cradle, hot packs, aces and

one pillow elevation. The patient apparently did not cooperate in keeping his aces and hot packs on. In any case he developed gangrene of the discolored area of leg and a toe, then his forefoot, and eventually went to the Mason Clinic for an above knee amputation. He apparently then returned to work in Fairbanks for over a year. Dr. Tatum was represented by Mr. Robert McNealy (retained by Lloyds). Mr. Johnson was represented by **Mr. Savage** of Anchorage, in cooperation with **Mr. Parrish** of Fairbanks. **Mr. Leonard Schroeder** of Seattle was again brought in on this case, as he is in so many of the medical malpractice cases on the west coast. He brought along two "expert" medical witnesses to Fairbanks, **Dr. Robert Coe**, a Seattle vascular surgeon, and **Dr. Fisher**, a Seattle internist. He also supplied the deposition of another "vascular expert" **Dr. Abby Franklin**, another Seattle internist. The claim of all these men was that the patient had an acute femoral bifurcation embolus and that he should have been sent immediately to Seattle for vascular surgery. Also that his embolus later must have moved down, since it obviously was not there when the leg was amputated. At amputation the femoral artery was found open. Also, even though at least two occlusions of the small vessels distal to the popliteal were demonstrated during an incomplete examination of the specimen, that these occlusions were (1) probably embolic from the heart and (2) probably wouldn't have caused trouble if heat had not been applied.

I had the privilege of two days on the stand in this case as an "expert vascular surgeon" and pointed out that all the limb vessels were severely narrowed, that there was no evidence of any embolus, that embolism was rare even with a recent heart attack; and that no embolus large enough to completely block the femoral bifurcation would disappear down an anterior or posterior tibial artery narrowed by atheroma to a lumen of one or two millimeters. Also that although heat application was contra-indicated there was no evidence that the leg was not lost solely because of severe atherosclerosis with multiple occlusions. After the "experts" had thus finished contradicting each other the jury was left with a case in which hospital records were inadequate, several people claimed the defendant did serious wrong, and with a plaintiff sitting in the court room wearing a prosthesis he could barely control while walking in the court room.

Several important points are brought up by this case. (1) Mr. Schroeder in particular and other

plaintiffs lawyers generally have taken the trouble to learn more “almost medicine” than most defense attorneys apparently can or do. This makes sense, for after all if a lawyer is going to study enough medicine to impress a lay jury with his knowledge he might as well go where the chance for big money is, and it certainly is as plaintiffs attorney. (2) Contingency fees. The plaintiffs lawyers claim that these are essential to permit the poor man to sue when necessary, and that if the physician would just practice good medicine and “stop being a businessman” he wouldn’t get sued. Yet, while the plaintiffs lawyer takes 1/3 to 1/2 of these large judgments, after expenses are deducted, no one ever hears the physician say “If I cure you I want one-half of all the money you’ll ever make.” Should not the plaintiffs lawyer treat the poor as the doctor does, i.e., “Pay my regular fee, or a reduced fee if you can,” or even with Welfare support when available? (3) Why are Alaskan physicians subjected to lawyers and medical “experts” from Seattle? We need a valid medical license to practice here, why should these men be permitted free access to us, when we have no comparable “specialist” lawyer available who does only medical liability defense work for the whole west coast.

Certainly if one searches long and far enough, one can get an “expert medical witness” who will

say anything one wishes, and **may** even be able to say it sincerely, either in ignorance or because it applies to his own ivory tower. Such men cannot understand, if they would, the problems of daily medical practice in Alaska, where each day one is called upon to care for something not quite “in his line” or specialty. If anyone has had previous legal encounter with **Mr. Schroeder** or especially with **Dr. Coe, Dr. Fisher** or **Dr. Franklin** as witnesses, we would be most interested in a brief summary of the circumstances. (4) With this type of decision and such judgment levels it is difficult to visualize the “plot” by the insurance companies that plaintiffs attorneys so often blame all our problems on. Hopefully Dr. Tatum will successfully appeal this unbalanced decision, although the situation at present in Alaska appears weighted heavily against the physician. The present situation could well result in the plaintiffs attorneys “killing the goose,” as more physicians depart or become unable to get adequate insurance. Possibly these attorneys could then convince the public health service to expand and provide needed medical care. There should be no limit to the judgments they could get with the government as defendant.

**LATE INFORMATION:** Lloyds decided not to appeal and case against Doctor Tatum settled for \$150,000 plus costs.

FOR THE LADIES

See Sitka at the Annual Convention in '67

There will be something of interest for all — clam bake, sight-seeing, banquets, social hours, and business meetings. Come by car, ferry or airplane—meet Miss Asher Yaguda, President of the Women’s Auxiliary to the American Medical Association.

PLAN NOW TO ATTEND



# THE REGIONAL MEDICAL PROGRAM FOR HEART, CANCER AND STROKE

By Donal Sparkman, M.D.

Dr. Donal Sparkman is Coordinator for the Regional Medical Program, Alaska-Washington region. He is currently based at the University of Washington Hospital in Seattle. Dr. Sparkman practiced internal medicine in Seattle for sixteen years. In 1959 he was appointed Clinical Professor of Medicine at the University of Washington. From 1960 to 1966 he was State Medical Consultant for the Washington Division of Vocational Rehabilitation, and he assumed his present full time position, along with an Associate Professorship of Medicine, in March of 1966.

The first knowledge most of us had of the Regional Medical Program came with the report of the President's Commission (DeBakey) on Heart, Cancer and Stroke mailed to all physicians in December, 1964. Of the thirty-five recommendations of the Commission those which received most attention were proposals for building new centers for research, training and patient care for heart disease, cancer and stroke. Though the DeBakey center concept was radically changed as the legislation to implement it passed through Congress, the image of the Regional Medical Program in the minds of most physicians was still that of a Federal medical program directing patients to a University medical center with little concern for the role of the private physician or the community hospital.

It did not come out this way. Those who are skeptical of the impact on Congress of the individual physician should read the hearings of the Heart, Cancer, Stroke bill before the House Subcommittee. Distinguished physicians and those less well known, aroused by the implications of the Commission report, appeared in person before the House Subcommittee or otherwise communicated with their Congressmen. While many expressed general approval of the bill, a number of witnesses questioned the need of such new centers and thought that any building should be preceded by a suitable period of planning. The Subcommittee was sufficiently impressed that they struck out the original bill and rewrote it incorporating many of the constructive recommendations of witnesses.

While the President's Commission had recommended the development of many new centers, the new bill focused on the peripheral community; on a decentralization of teaching and of

patient care. The bill as it emerged has unusual features which make it attractive to the medical profession. It is not a Federal blueprint directing the way in which it shall be implemented. Rather it is brief, broad in concept and with considerable latitude as to its operation. It encourages local initiative in determining community needs and in planning to meet them; it stresses cooperative planning among physicians and others to make best available use of health resources in the region. There are no provisions for new construction, no funds for patient care. There is to be no interference with the relationship of the practicing physician with his patient, no alteration in administrative hospital practices.

Recognizing the potentialities of the legislation while it was still before Congress, Dean John Hogness of the University of Washington School of Medicine, began discussing it with officers of the Medical Associations of Washington, adjoining states, and Alaska; with the governors of Washington and Alaska, and with Congressional representatives and leaders in voluntary health agencies. There was general approval of the bill as it emerged from Congress and shortly thereafter Washington's Governor Evans concurred in a recommendation that the University serve as the applicant for a planning grant. Governor Egan of Alaska, Dr. Royce Morgan of the Alaska Medical Association, and Dr. Levi Browning, Commissioner of Health and Welfare, among others were in agreement that Alaska join Washington in forming a region for planning under the Heart, Cancer, Stroke bill, and this proposal was readily accepted by the Washington group.

A regional advisory committee was appointed from candidates offered by a broad representation of interested health organizations in the two states and included citizens appointed by the two governors. At its first meeting the Regional Advisory Committee recommended that the two states combine in a region under the Regional Medical Program. An application for this purpose was submitted to the National Institutes of Health in July, approved in September, 1966. The resulting grant is for planning only and makes available funds for gathering data as to the existing re-

sources and needs in providing health care for heart disease, cancer and stroke in Washington and Alaska, as well as an appraisal of the existing programs and needs in continuing education.

Alaska representatives (Bruce Wright, Alaska Medical Association; Levi Browning, Alaska Commissioner of Health and Welfare; Judge Thomas Stewart, Alaska Heart Association; and James Lanham, Alaska Cancer Society, have faithfully attended meetings of the Regional Advisory Committee where they have vividly portrayed the unique as well as routine features of health care and continuing education in Alaska. Communication between the two states regarding the Regional Medical Program was enhanced by a visit of Dr. Lowell White, Associate Dean of the University of Washington School of Medicine, to Anchorage and Fairbanks in June, 1966, at which time he met with members of the Alaska Medical Association and the University of Alaska faculty. In December, 1966, at the invitation of Alaska representatives to the Regional Advisory Committee, Drs. Pat Lynch, Yakima Radiologist and a member of the Regional Advisory Committee, and Don Sparkman, Coordinator of the Regional Medical Program, visited Anchorage, Fairbanks, Ketchikan, Juneau and Sitka, meeting with members of the local medical society and others in the health professions at each location. In Juneau it was their privilege to discuss the Regional Medical Program with Governor Hickel, and in Fairbanks to meet with members of the faculty of the University of Alaska.

Throughout their trip interest was evidenced in the RMP and in particular in the possibility of augmenting continuing education efforts for physicians, nurses and technicians. In addition to the

possibility of scheduling more regular teaching visits by individuals and teams of experts, questions were asked about the possibility of arranging training sessions of one to four weeks duration for practicing physicians in fields of their choice in Seattle hospitals. The use of newer communication devices such as video tapes, instant consultation, and single concept films were considered as adjuncts to more conventional consultation and teaching devices.

The trip served as an equally important learning experience for the visitors who saw firsthand some of the unusual and often fascinating facets of life and the practice of medicine in the 49th State, not to mention its scenic splendors which exceeded expectation. Increased respect for the Alaska physician in both urban and rural areas was gained as the trip progressed.

While the distance between Alaska and Washington presents special problems to the functioning of the two-state area as a region within the Regional Medical Program, the eagerness of physicians in each state to improve communications and relations between them plus the advances in both transportation and communication makes this joint effort a reasonable possibility. In this time of rapidly expanding medical knowledge, with health care expectations exceeding our capacity to meet them, this program offers physicians an opportunity to plan ways in which they may better keep abreast of the rapidly changing medical scene and make best use of scarce health personnel and resources. Whatever benefits do develop in Alaska will be in response to Alaska physicians' initiative and requests. Questions and comments should be directed to the Alaska State Medical Society, Committee on Heart, Cancer and Stroke.





# PROFESSIONAL LIABILITY INSURANCE

By Rodman Wilson, M.D.

Dr. Rodman Wilson has practiced Internal Medicine in Anchorage for eight years and is presently chairman of the Anchorage Medical Society Legislative committee. The following is an address delivered to the Anchorage Press Club on January 18, 1967.

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What is malpractice? It is the dereliction of professional duty by a doctor or his assistant resulting in harm to a patient. The dereliction can be willful, criminal, or due to negligence, but since willful and criminal negligence are rare, one ordinarily implies negligence when speaking of malpractice by a physician. And since a physician is human, he can and does make unintentional mistakes, often from being too busy or too tired, or from being preoccupied with other professional or even personal problems.

When negligence occurs or seems to occur, a patient will sometimes sue a doctor for the real or imagined damage done. One reason for believing that an unfavorable outcome of a contact with a doctor has occurred comes from misunderstanding the nature of disease and the healing arts. We all read and hear about the wonderful accomplishments of medical science, about "miracle" cures and amazing surgery. A patient understandably may become disappointed, bewildered, and disgruntled when he too cannot have a miracle or an amazing recovery from his ailment. He may even be disappointed if his doctor does not behave in the grand image of the television doctor or old Dr. Gillespie. Patients often do not realize how much doctors do not know, and that cures for many conditions are not to be had anywhere, not in Anchorage, in San Francisco, in New York, or London, or Stockholm. Further, some patients do not appear to know that many conditions worsen in their natural course. A patient may wrongly attribute the worsening to the treatment rather than to the disease, and feel that it is the doctor's fault that he is worse. Some individuals do not realize that they take a risk whenever they step into a doctor's office—a risk that the potent medicines and other forms of treatment today may harm them no matter how learned and careful the doctor prescribing them may be. When you take your flat tire to the garage, you can regularly expect that it will be satisfactorily fixed or replaced. Not so when you take your ailing heart to the doctor. Medicine is not that simple.

For protection from malpractice judgments arising from such lawsuits, a doctor buys professional liability insurance. Rates for such insurance have been rising throughout the country in recent years, but have risen astronomically for many physicians in Alaska within the past year, ostensibly because of a judgment against an Alaskan physician in which an untoward result following surgery was adjudged not to be due to negligence on the part of the doctor but was adjudged to be worthy of an award merely because a poor result had occurred. In other words a doctor has to get a good result, or risk being sued. This decision by the Alaska Supreme Court has apparently made many insurance companies unwilling to insure—at least at previous rates—Alaska physicians. Accordingly some physicians are presently without liability insurance, others are having to pay rates that they consider exorbitant for less coverage than they had before, other physicians in relatively low-risk non-surgical practices continue to pay rates which have not changed appreciably, and in one instance, which seems rapacious to me, a physician was insured (for low coverage) only when he transferred his auto and home insurance from one Anchorage agency to another.

But the problem of professional liability existed before the above cited case and seems largely to do with a prevailing attitude and mode of behavior in the United States which says that one should not bear the brunt and burden of his misfortunes in life. If he is burdened with aged, infirm parents, they should be placed in a nursing home at government expense so that his life will not be hindered by them. If his child is severely mentally retarded, it is the State's job to assume care and costs, and if he himself is injured physically, emotionally or otherwise, SOMEONE, certainly not he himself, is going to have to pay for it. I suppose that when the golden social millenium comes all misfortunes from cradle to grave will carry dollar awards. If these are automatic at least it will serve to eliminate all the troublesome, costly, painful litigation and will allow one to get on with the important, worthwhile work of the world (if there be any left to do in the golden social millenium). But at the present, when one is hurt he seeks as hard as he can with as smart an advocate as he can find to capitalize on his misfortune—to be paid for his injury. Now

this is not just payment for his medical expenses but for his mental anguish (by the day and hour sometimes), for his inconvenience, possibly for the temporary loss of enjoyment of his wife, and for all he might have earned if he had lived to a hale and hearty 65 or beyond; not considering, of course, that life always brings further vicissitudes which might alter the flow of money calculated so meticulously on court room blackboards. When he is successful in cashing in on his misfortune, he splits the award with the lawyer. This makes up, in part, for the cases the lawyer takes and loses, getting little or nothing.

My basic objection to this mode of behavior is that it is an unproductive, uncreative way of life and that it counsels a negative attitude toward one's fellow man. It involves much loss of time on everyone's part. It even hurts a doctor's other patients, for there are few things which upset a physician more than to be sued. It shatters his confidence in himself and in a cherished way of life. Under these circumstances he can hardly be an effective doctor to his other patients, at least until the suit is settled.

I feel, then, that relief is needed somehow or another from the threat and burden of large malpractice suits. One element of relief would come with legislation which would require proof of negligence and place the onus of proof of negligence on the plaintiff. This would counteract the recent ruling of the State Supreme Court, in the opinion of some, and would put us back even with the other states, none of which has so unusual a precedent to my knowledge.

But more is needed to really come to grips with the problem. Alaskans, for a change, could lead the way to a solution, rather than to wait, as is so often the case, for leadership from some other State. Suggestions advanced have been (1) compulsory arbitration of medical malpractice claims before a committee of lawyers, physicians, and laymen (2) mandatory expert testimony to the court (3) statutory limitation of awards for losses (4) abolition of contingency fees in malpractice cases (5) a State system of professional liability insurance which could cover other professions such as dentistry, insurance, accounting, and law.

I strongly advocate some such legislative relief. It is sorely needed to continue to make the practice of medicine attractive in Alaska. A doctor must be able to express himself professionally without fear of personal economic disaster from a lawsuit. Doctors, even now, who are planning to settle in Alaska are being advised not to do so until the climate is more favorable in these matters.

If relief is not obtained, some doctors may leave, others will not come, and even more importantly, there is a significant danger of stultifying medicine by producing a breed of pusillanimous milque-toast physicians who are afraid to take bold, imaginative, highly tailored, highly specific courses of management for their patients, for fear of being sued because the approach was not usual or orthodox. In the long run orthodoxy and standardization breed mediocrity and eventually make a system anemic and lifeless. I for one do not want this for medicine, and I do not believe that you do either.





# PROPOSED MEDICAL LIABILITY ACT

## With Cover Letter

February 8, 1967

The Honorable Walter J. Hickel, Governor  
State of Alaska  
State Capitol—Juneau, Alaska

Dear Governor Hickel:

Enclosed is a copy of a bill which has been drafted at the request of the Alaska Medical Association. The purpose of the bill is to clarify a situation which has arisen as a result of a 1964 Supreme Court decision. The decision that we are referring to is the case of Patrick vs. Sedwick.

That decision has clouded the air with respect to the burden of proof in cases wherein physicians are sued for malpractice. The decision appears to put the burden of proving innocence on the part of the defending physician in such cases. While we cannot be certain that the Supreme Court of Alaska intended that to be the result of its decision, the fact is, however, that insurance companies throughout the nation which offer malpractice coverage have interpreted the decision to mean that the case law in Alaska now requires the defending physician in a malpractice case to prove his innocence. As a result of this, a number of insurance companies have withdrawn from the field of offering malpractice coverage to Alaska physicians. In addition, the rates of the few companies still offering coverage to Alaska physicians have increased to the point where many physicians find the cost of malpractice coverage to be prohibitive.

The uncertainty created by the impact of this decision on those in the business of offering insurance is working to the detriment not only of Alaskan physicians but also to the detriment of the citizenry of Alaska who are indirectly benefited through the availability of such coverage. It is important that the law be clarified. The copy of the bill that we have submitted to you is designed to remove the uncertainty as to the procedure the courts will apply in medical malpractice cases and to clearly establish the rule that the plaintiff-patient bringing an action against his physician must prove his case by a preponderance of the evidence. The rule applies in all civil cases, and this bill is designed to make it clear that the same rule should apply in civil malpractice cases.

It is probably not likely that the Alaska Supreme Court meant to upset this well established rule of procedure; but unfortunately until another case reaches the Alaska Supreme Court, the situation in Alaska with reference to suits against doctors for malpractice is up in the air. That being the case, malpractice coverage has become unavailable to a number of Alaska physicians. This bill clarifies the law without waiting for the Alaska Supreme Court to bring forth another decision. This latter could take years since the court has no control over what cases are brought before it. The situation as it presently exists in Alaska has caused physicians contemplating practice in Alaska to change their minds about coming here at all. Alaska needs physicians. The shortage that exists already will become more severe. This is not simply theory on the part of Alaska physicians. We have had letters and comments from outside doctors who have changed their minds about practicing in Alaska because of the uncertainty of the legal situation. A number of Alaska doctors are so concerned about these uncertainties that they are contemplating establishing practice elsewhere.

The bill we have drafted is not a special interest bill. It provides only that the plaintiff bear the burden of proof in malpractice suits against doctors just as the plaintiff must do in every other case wherein he files suit. We are not asking any privileges that are not accorded to every other citizen of the state when and if he should be sued in a court of law.

Sincerely,  
Alaska State Medical Association

### AN ACT

**Relating to medical malpractice actions in Alaska based on negligence; setting the standards of knowledge and skill required of physicians practicing in Alaska; and establishing the burden of proof in such cases.**

**Be it enacted by the Legislature of the State of Alaska:**

In any malpractice action based on negligence against a physician licensed under this Chapter, the plaintiff will have the burden of proving:

- (1) That the defendant physician either lacked the skill or knowledge, or failed to exercise the degree of care, commonly possessed or exercised by other physicians in the same specialty in the community where such defendant practices; and
- (2) That the plaintiff suffered injuries that would not otherwise have been incurred as a proximate result of such lack of knowledge, or failure to exercise such skill.

In each case the plaintiff will have the burden of proving by expert medical testimony (1) the degree of knowledge possessed, or the degree of care ordinarily exercised, by physicians of the same specialty practicing in the community where the defendant practices; and (2) that the defendant failed to possess such knowledge, or failed to exercise such degree of care, in the particular case.

In no case at law may negligence on the part of a physician or surgeon be presumed; it must be affirmatively proved.

The jury shall be instructed that in cases where diagnosis or treatment, or both, involve risks of injury or disability to the patient, the patient has the burden of proving by a preponderance of the evidence that the injury or disability alleged to have been suffered by him came about as the result of negligence on the part of the physician and the jury shall be further instructed that the fact of injury or disability alone is not proof of negligence on the part of a physician.

In trials to the court sitting without a jury, the same principle shall be applied by the court.



# LEGISLATIVE ABSTRACTS

The following bills of interest to the medical community have been introduced into the Alaska Legislature for consideration.

## SENATE BILLS

- S.J.R. 2: Christiansen and Blodgett: "Relating to the establishment of a hospital at St. Mary's and Unalakleet." Referred to the HEW. 1/30/67
- S.B. 10: Ziegler: "An Act requiring that drivers license show that licensee's blood type; and providing for an effective date." Referred to State Affairs and Finance Committee. 1/23/67
- S.B. 40: Bradshaw: "An Act relating to the Board of Nursing and its executive officer." Referred to HEW Committee. 1/30/67
- S.B. 53: Thomas, Smith, Palmer, Koslosky, Bradshaw, Begich, Brady and Harris: "An Act relating to licensure of psychologists; and providing for an effective date. Referred to HEW and Judiciary Committees. 2/2/67
- S.B. 55: Begich and B. Phillips: "An Act requiring continuing education of dentists." Referred to HEW Committee. 2/2/67
- S.B. 62: B. Phillips, Harris and Brady: "An Act relating to licensing of dentists; and providing for an effective date." Referred to HEW. 2/3/67
- S.B. 70: Brady: "An Act relating to the Uniform Narcotic Drug Act." Referred to HEW Committee. 2/6/67
- S.B. 79: B. PHILLIPS: "AN ACT RELATING TO MALPRACTICE ACTIONS." REFERRED TO HEW AND JUDICIARY COMMITTEES. 2/8/67. THIS BILL WAS LATER (APPROXIMATELY FEBRUARY 14, 1967) WITHDRAWN BY MR. PHILLIPS.
- S.B. 80: Haggland and Ziegler: "An Act relating to the formation of professional corporations; exempting professional corporations from the provisions of the Alaska Employment Security Act; and providing for an effective date." Referred to Commerce and Judiciary Committees. 2/8/67
- S.B. 89: Rules Committee by request of Governor: "An Act relating to civil liability for rendering emergency aid to accident victims; and providing for an effective date." Referred to the Judiciary Committee 2/10/67
- S.B. 93: Palmer and B. Phillips: "An Act providing for the prevention of air pollution." Referred to HEW Committee. 2/10/67

## HOUSE BILLS

- H.J.R. 2: By a host of Representatives: "Relating to the establishment of a hospital at Andreafsky." Referred to the State Affairs Committee.
- H.J.R. 4: Hohman: "Relating to the funding of the Bethel pre-maternal and foster care homes." Referred to the State Affairs and HEW Committees. 1/31/67
- Passed House of Representatives 2/9/67.
- H.C.R. 7: Fritz: "Relating to the use of Alaska Medical and allied health facilities." This resolution concerns itself with urging the use of medical specialties and facilities which are available in Alaska. Passed the House of Representatives 2/3/67.

- H.C.R. 9: Fritz: Relating to the need for facilities for the disposal of human waste." Referred to Local Government and HEW Committees. 1/31/67
- H.J.R. 17: "Relating to support for the implementation of Public Law 89-749." Referred to the HEW and Finance Committees. 2/9/67
- H.C.R. 19: Fritz: "Relating to vision and hearing equipment at the Pioneers Home." Referred to the State Affairs and Finance Committees. 2/8/67
- H.C.R. 20: Fritz: "Relating to health personnel at the Pioneers Home." Referred to the State Affairs and Finance Committees. 2/8/67
- H.B. 22: Ray: "An Act relating to the giving of aid to victims of emergencies." Referred to HEW and Judiciary Committees. 1/23/67
- H.B. 31: Fink, Borer, Beirne, Fritz and Orbeck: "An Act relating to drivers' licenses, and providing for an effective date." Requires blood type be shown on license and applicant's personal physician listed. Referred to State Affairs Committee. 1/23/67
- H.B. 68: Fritz: "An Act relating to eyeglasses and sunglasses." Referred to Commerce Committee. 1/27/67
- H.B. 73: Fritz, Beirne and Bradner: "An Act relating to the disease Phenylketonuria; and providing for an effective date." Referred to the HEW and Finance Committees. 1/31/67
- H.B. 74: Fritz: "An Act appropriating to the Department of Health and Welfare; and providing for an effective date." Provides for an appropriation of \$10,000 for the cost of personnel and testing materials described in H.B. 73. Referred to HEW and Finance Committees. 1/31/67
- H.B. 90: HEW Committee: "An Act relating to the Board of Nursing and its executive officer." Referred to Commerce and HEW Committees. 1/31/67
- H.B. 115: Moses and Ray: "An Act relating to the giving of aid to persons in need of medical care and assistance." Referred to HEW and Judiciary Committees. 2/3/67
- H.B. 127: BEIRNE: "AN ACT RELATING TO MEDICAL MALPRACTICE ACTIONS." REFERRED TO HEW AND JUDICIARY COMMITTEES. 2/6/67
- H.B. 130: Beirne and Fritz: "An Act relating to the licensing of Physical Therapists." Referred to Commerce and Finance Committees. 2/7/67
- H.B. 131: Beirne: "An Act relating to the time a child must be abandoned before an order terminating parental rights is entered and providing for an effective date." Referred to HEW and Judiciary Committees. 2/7/67
- H.B. 132: Beirne: "An Act relating to the membership of the State Medical Board." Referred to Commerce and HEW Committees 2/7/67
- H.B. 178: Beirne: "An Act relating to chemical analysis of blood in prosecution for driving under the influence of intoxicating liquor." Referred to the Judiciary Committee. 2/14/67
- H.B. 179: Beirne: "An Act relating to implied consent to chemical tests as to alcohol content of blood." Referred to State Affairs and Judiciary Committees. 2/14/67



# EXTENSUALIS OBSTETRICUS

—A Fable—

*Anonymous*

Once upon a time there was a good, intelligent, conscientious physician named Smith-Jones, who practiced in a far-off country called Aksala. He loved his country, his patients, and his trustworthy friends. He had a patient named Mrs. Brown, who had had two pregnancies, one ending at six weeks and one at three months in spontaneous abortion. He had another patient with identical difficulties named Mrs. Smythe. Because he was a good and knowledgeable physician who loved people and babies, he treated both Mrs. Brown and Mrs. Smythe with thyroid, Progesterone and maybe a little dab of Marezine and perhaps some vitamins; and allowed his nurse to do routine urine checks in his small laboratory.

Now it came to pass that Mrs. Brown had a Fine Baby Boy and was exceeding glad and rejoiced. And one week later, Mrs. Smythe had a Fine Baby Girl and was exceeding glad and rejoiced.

But—

One year later it became plain for all to see that Mrs. Smythe's baby was inferior, and had crossed eyes, and cried occasionally, and exhibited deficiencies in her reflexes.

Dr. Smith-Jones assured Mrs. Smythe that her pre-natal care had been good and conscientious and, in fact, identical with that of Mrs. Brown, and that her daughter's condition wasn't unexpected since Mrs. Smythe and her brother and his sister and her mother also had crossed eyes and deficient reflexes.

But—

Mrs. Smythe read the newspaper, and THYME and NEWMONTH and that indisputable medical journal, LOOKER'S DIGEST; she also had a pharmacist friend who read all the releases from the FDA (Fraternal Drug Advisors). They both had friends who were S.J.'s, which, in this country, means Seekers of Justice. The S.J.'s found that the FDA had listed Thyroid, Progesterone, and Marezine as dangerous drugs since, in excessive

doses, they could cause deformed babies in a very rare breed of Australian Platypi. The FDA also found that large doses of caffeine could cause deformed babies in guinea pigs. Therefore, they concluded that Dr. Smith-Jones had erred grievously in using these drugs to assist Mrs. Smythe in producing a full-term baby and Mrs. Brown to have a Bouncing Baby Boy. The S.J.'s also decided that Dr. Smith-Jones should have interdicted coffee even though millions of pregnant women had had their morning coffee (Indeed, their mid-morning coffee, their noon coffee, their early afternoon coffee, their mid-afternoon coffee, their late afternoon coffee, their dinner coffee, and their evening coffee) without apparent influence on their issue.

And so it came to pass that Dr. Smith-Jones was relieved of his practice, his home, his auto, and his expensive cigar lighter (and in the process, his admittedly rather flighty young wife) because a jury of his pee-rs decided that he had administered dangerous drugs, and because he hadn't requested a 19 Keto-synergy-B-S-orthodiabolic acid test which would have determined the presence of the cross-eyed genes! (He didn't know about the test because it had only been described six weeks after the babies were born, in THYME magazine.)

Whereupon, Dr. Smith-Jones resigned from the practice of medicine in Aksala, and betook himself to a place called Bathing Ton, and after taking a 5-year course in stagnation and bigotry, he qualified for an eminent position with the Fraternal Drug Advisors Bureau.

P. S.—Careful investigation revealed that Mrs. Brown had three more Bouncing Baby Boys, and Mrs. Smythe had three more cross-eyed, reflexless daughters.

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*Anonymous*

From ENCYCLOPAEDIA UNIVERSALIS, Year 2556  
"History of Ancient Medical Practice; Fables of the Tyme," pp. 1637-1966.

# LIVER SCANNING

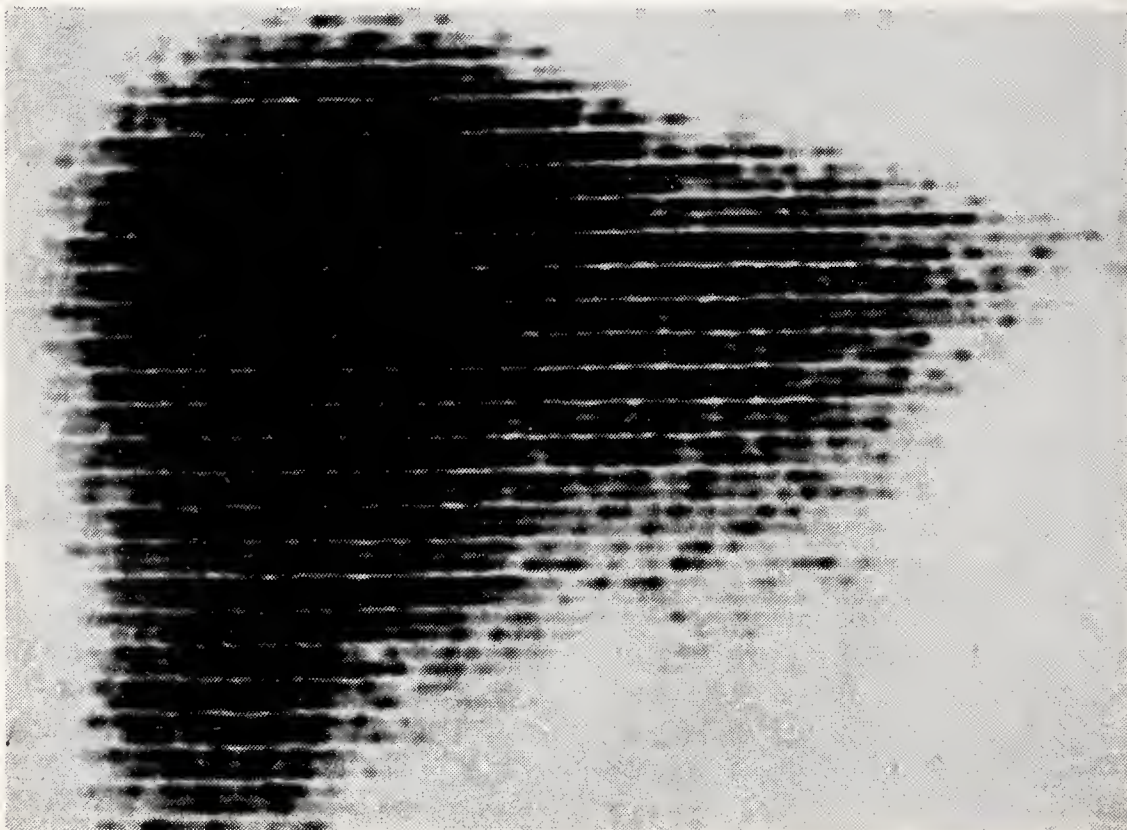
By Bruce Wright, M.D.

It is well known among radiologists that estimation of liver size radiographically can be grossly erroneous. Special studies such as splenoportography and celiac axis angiography can be used to evaluate the liver. These procedures are difficult to perform, expensive, time consuming, and not without possible patient hazard. The radioisotope liver scan is a safer, less expensive, more easily performed, and more easily interpreted study, providing a high degree of reliability. The hepatic scan provides a visual image of the liver as a functioning organ, especially regarding size, shape, and presence of space occupying masses. Among the several radioisotope compounds currently in popular use for "mapping" the liver, the Department of Radiology at Providence Hospital utilizes Colloidal Gold 198 ( $\frac{1}{2}$  life 2.8 days). Tiny particles of colloidal gold are phagocytosed by the reticuloendothelial cells. The fact that the radioactive gold remains in the cells for a period of time permits patients to be re-scanned on subsequent days. It is possible to obtain adequate scans in the presence of parenchymal disease or with a severely jaundiced patient.

Following an intravenous dose of colloidal gold, approximately 80% is cleared by the Kupffer cells. Clearance is practically complete within 30 minutes. As this material is cleared by the reticuloendothelial system, uptake is not dependent upon hepatic parenchymal function, but is dependent in general upon liver blood flow and the integrity of the Kupffer cells. Since the substance is not handled by the parenchymal cells, an accurate estimation of liver function is not possible. However, since liver disease almost always affects both parenchymal and reticuloendothelial compartments, the colloidal material actually is useful in gauging liver function, except in judging obstruction to the biliary tree.

The most important clinical aspect of hepatic scanning is the demonstration of space occupying masses within or adjacent to the liver. The liver scan has been shown to be useful for detecting primary carcinoma of the liver, hydatid cysts, liver abscesses, and extra-hepatic tumor. It is also of value in patients undergoing therapy wherein serial scans of the liver can be obtained to observe the effects of chemotherapy, radiation, or surgery.

Clinical determinations are often inadequate



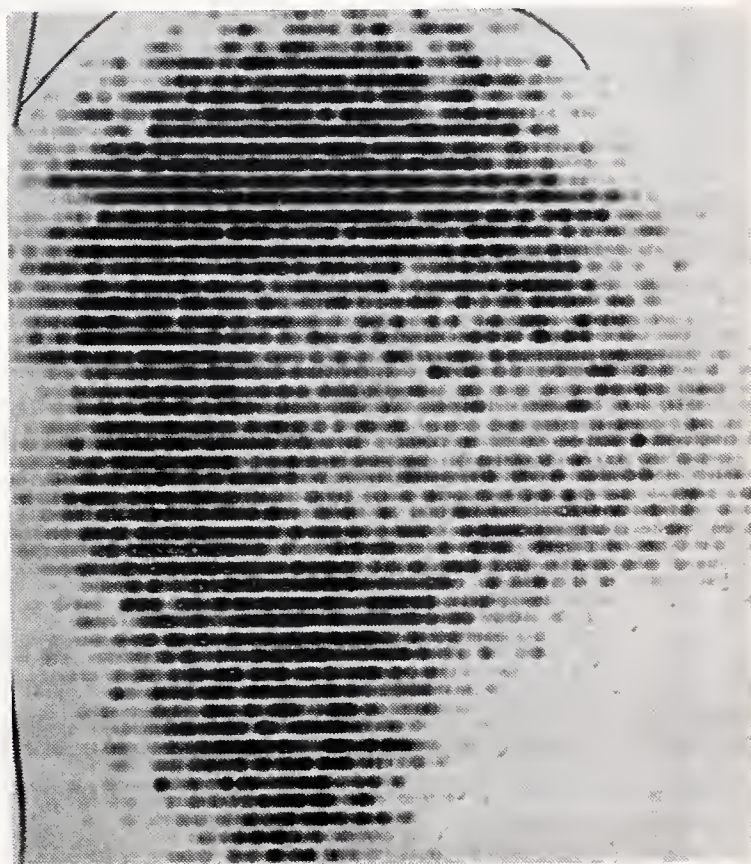
(1.) Normal Liver



in excluding metastatic disease and a liver scan may be extremely helpful, even before the liver enlarges or chemical changes occur. Photoscan localization of large metastatic deposits are helpful in liver biopsy. Depending upon the depth of the lesion and the area, the smallest lesions that can be detected run about 3 cm. in diameter. The liver scan can be superimposed on a survey film of the abdomen taken at a six foot distance. This is useful for describing subphrenic abscesses or in ruling out these lesions when liver can be seen to clearly occupy all the area beneath the right hemidiaphragm. Shown in the accompanying pictures are: (1) a normal liver; (2) metastatic disease in the liver; this pattern of multiple discrete defects may also be seen in multiple abscesses, hematomata and rarely in cirrhosis; (3) shows a cirrhotic scan; this patchy decrease in uptake may also be seen in biliary cirrhosis, hepatitis, or diffuse infiltrative metastatic disease; (4) demonstrates a single large central liver abscess. This pattern is also seen in hydatid disease, hepatoma, or huge solitary metastatic lesion.



(3). Cirrhotic Scan



(4.) Central Liver Abscess

### SUMMARY

Radioisotope scanning of the liver at present represents the safest, simplest, and most effective method of depicting the size, shape, position, and appearance of the liver. 85% to 90% reliability of interpretation can be achieved.

(2.) Metastatic Disease



# TENTH ANNUAL LEDERLE SYMPOSIUM FOR ANCHORAGE

A decade of annual post-graduate sessions for Alaska physicians was observed on February 25, 1967, when the tenth annual medical symposium sponsored by the Anchorage Medical Society and Alaska Chapter of the American Academy of General Practice was conducted at the Anchorage-Westward Hotel.

Made possible by a grant from Lederle Laboratories, the Anchorage symposia have attracted a total attendance of 938 physicians from throughout the state.

Gerald Egelston, manager of educational services for Lederle Laboratories, reported that Anchorage, because of its size and location, is the only city in the nation in which the symposiums have been repeated for ten successive years. Attendance is acceptable for six hours of continuation study credit by the American Academy of General Practice.

The first five Anchorage meetings were designated as "post graduate seminars with round-table discussions." Since 1963, each of the annual meetings has been identified as a "Symposium."

Program chairman for the first post-graduate session in 1958 was Dr. George Hale. Medical educators traveling to Alaska for the initial meeting were Dr. Charles Bailey, Professor of Thoracic Surgery at Hahnemann Medical Center, Philadelphia; Dr. Fred M. Taylor, Associate Professor of Pediatrics, Baylor University College of Medicine, Houston; Dr. Walter S. Priest, Associate Professor of Medicine, Northwestern University Medical School, Chicago, and former president of the American Heart Association.

Moderators for the pioneering session were Anchorage Doctors Francis J. Phillips, John C. Tower and Robert B. Wilkins. Attendance at the first session was 77 physicians.

Program chairman for the 1967 symposium was Dr. Frederick J. Hillman. Visiting speakers were Dr. Matthew Block, Professor of Medicine and Chief, Hematology Division, University of Colorado Medical Center; Dr. Rene B. K. Menguy, Professor and Chairman, Department of Surgery, University of Chicago Medical School, and Dr. Martin M. Hoffman, Associate Professor of Medicine, McGill University Faculty of Medicine, Montreal. Moderators for the tenth symposium were Doctors Frederick R. Hood and Winthrop Fish.

As an outgrowth of this year's session, Doctor Hoffman rearranged his return schedule to stop off at Ketchikan, where he delivered his Anchorage papers to the medical staff of Ketchikan General Hospital on the evening of February 26 and morning of February 27.

In prevailing on Doctor Hoffman to stop off at Ketchikan, Dr. Arthur Wilson pointed out that the First City is nearly 1200 miles from Anchorage, and it requires a full day coming and going to attend the Anchorage meeting. The Ketchikan stop-over for Dr. Hoffman was sponsored by the Alaska Chapter of the American Academy of General Practice.

Since the first Lederle-supported symposium was held in Knoxville, Tennessee in 1952, more than 135,000 physicians have attended more than 500 symposia in more than 200 different cities in the 50 states.



*Mr. Gerald Egelston, manager of education services for Lederle Laboratories, who has assisted with each of the ten symposiums conducted in Anchorage. For his work, Mr. Egelston was recently awarded honorary membership in the Anchorage Medical Society, first non-physician so honored.*



A colonel in the Pacific Theater in World War II, Mr. Egelston and his four-member staff work up to 16 months ahead in planning the symposia. More than 760 medical specialists have appeared on the programs, reporting on a wide range of medical and surgical techniques, development and problems.

For his decade of work in Anchorage, Mr. Egelston was presented a certificate of honorary membership in the Anchorage Medical Society on February 25, the first non-physician so honored. He had previously been given special recognition by the California and Kentucky Academies of General Practice, the American Medical Women's

Association and the Peoria County (Illinois) Medical Society.

As a special tribute to Alaska's Centennial year and its tenth successful symposium, Dr. Benjamin W. Carey, Medical Director of Lederle Laboratories Division of American Cyanamid Co., directed that more than 100 pounds of vitamins and anti-biotics be presented to St. Mary's Mission on the lower Yukon River. The Mission had reported its supply of vitamins was almost exhausted.

The special gift was presented by Mr. Egelston on February 23 to Rev. Rene Astruc, S.J., Jesuit Superior of St. Mary's.



*This slide was the first one shown at a medical meeting in Alaska after it became a state. It was flashed on the screen at the symposium on Anchorage on Feb. 21, 1959. Target for the young state is Texas.*

# PERIPHERAL VASCULAR SURGERY IN REVIEW

By Arndt von Hippel, M.D.

Having attended medical school during the slow breech delivery of modern vascular surgery, I was taught much decriptive material that was soon outdated. Over the past ten years, with improvements in materials and techniques, we have progressed from repairs through simple but risky replacements to generally satisfactory major vascular reconstructions. I have been impressed during this time with the relative ease of acquiring technical know how and proficiency, compared with the difficulty in developing a coherent approach to vascular problems. The following is one man's approach to peripheral vascular surgery, minus most of the "magic word" and "knock the wood" factors. I hesitate to expose it in its simplicity after so many years in its pursuit.

An accurate diagnosis of acute arterial or venous occlusion can usually be made from the manner of onset and the changes noted in the involved area. Let us consider first the legs. A sudden onset of pain, numbness, tingling, pallor, and coolness suggests an arterial obstruction. A more gradual onset of pain with aching and swelling is typically venous. Major swelling means venous and **not** arterial obstruction regardless of whether the leg is purple, blue, mottled, or white, and regardless of the peripheral pulse.

Often in an ischemic limb of borderline viability the patient is unable to wiggle his toes. Veins on the ischemic foot are flat and almost transparent. With major venous occlusion the superficial veins on the thigh and often even the lower abdomen are abnormally prominent.

## ILEOFEMORAL THROMBOPHLEBITIS

When the swelling extends to the inguinal area (and it is not due to infection, injury, or tumor) the diagnosis is "ileofemoral thrombophlebitis." At this stage the clot is well up the iliac vein and often extends into the vena cava.

An acute ileofemoral thrombophlebitis can properly be treated by surgery and/or heparinization. Selection of treatment depends upon the duration and progress of the thrombosis, and upon the facilities and skill available. A venous thrombectomy performed by the self-taught and occasional vascular surgeon is more dangerous than medical treatment.

## Venous Thrombectomy

If the leg is acutely swollen and the patient ill, and if the disease appears to be progressing, thrombectomy should be considered. This procedure is performed under local anesthesia to permit patient cooperation. A Valsalva maneuver is helpful during the evacuation of clot from the inferior vena cava. At least four units of blood should be available for immediate use. When properly performed through a femoral vein incision, clot can be extracted all the way from the vena cava down to the ankle veins with little risk of pulmonary embolus. The clinical response to thrombectomy is dramatic, as the toxic and often semi-stuporous patient rapidly becomes alert and cheerful. The leg usually approaches normal size within twenty-four hours. The general toxicity seen with this condition is probably due to the massive sequestration of extracellular fluid in the leg.

Thrombectomy appears to be followed by little or no venous disability. Venous ligation concurrent with thrombectomy is unnecessary and undesirable, whether saphenous, femoral, or caval, as it leaves a stagnant venous bed ripe for more complications. Relative contraindications to thrombectomy include a self-limited phlebitis or one which has started to improve, and an almost absolute contraindication is a patient to whom heparin cannot be given, as heparin is necessary for successful thrombectomy. Strict bed rest, a well padded foot board, elevation of the legs, and vigorous heparinization should be part of any therapy for ileofemoral thrombophlebitis unless anticoagulants are contraindicated. Vena caval ligation should be reserved for the patient who cannot tolerate anticoagulation, or who has recurrent pulmonary emboli while well anticoagulated, or septic phlebitis. When emergency thrombectomy is performed I like to give the initial heparin dose directly into the femoral artery. Hopefully this gives the maximal effect where needed most.

## HEPARIN THERAPY

A word on heparin therapy. This is far preferable to the coumadin type of anticoagulant in the treatment of acute thrombotic processes. I might say here that heparin therapy within several days after **arterial** surgery is dangerous and rarely



indicated (see discussion below). I have found the following heparin regimen effective. After a control Lee-White clotting time, aqueous heparin (usual dose range 50-100 mg., 5,000 to 10,000 units) is given deep subcutaneously every six hours. To avoid distressing hematoma formation a sharp disposable long 23 or 24 needle should be used. The needle should not be burred by previous puncture of a rubber vial top. To assure adequate rotation of puncture sites many prefer to draw a target grid on the skin of the abdomen, thigh, or flanks.

The aim of this heparin regimen is to elevate the five hour venous clotting time (drawn five hours after the last dose) to about 15-20 minutes. The heparin dosage has to be carefully regulated. Even after stabilization a daily clotting time is done. The heparin consumption often seems to decrease as the thrombotic process subsides, and cumulative effects are common.

### AMBULATION

Following venous thrombectomy and/or bed rest and heparinization the patient is not ambulated until the leg is asymptomatic and minimally tender. Then a progressive ambulation schedule is started while fully heparinized until the patient can walk without symptoms. Should long term anticoagulation be planned, an adequate suppression of prothrombin time must precede the discontinuation of heparin. We have kept most of these patients on Coumadin for 3-6 months when there was no contraindication.

### ACUTE ARTERIAL INSUFFICIENCY

On the arterial side one must decide whether to fish for clot, or cut ganglia, or anticoagulate. Emergency sympathectomy has not worked out well. External heat or elevation of the leg should not be used, as heat will increase the metabolic demand for blood while elevation will further decrease the perfusion pressure. We are left with a horizontal patient either in surgery or in bed. In either situation dehydration must be avoided.

When balancing emergency arterial surgery against anticoagulants one is more tempted to do surgery if the patient is young, and has healthy vessels, if the occlusion is most likely embolic, if the vessel block is proximal, and if the occlusion was recent within hours. Pushing one toward anticoagulation would be a generally arteriosclerotic patient, possibly with hard femoral vessels and missing pedal pulses on the opposite leg. Also against **emergency** surgery is a distal

level of occlusion, say below the popliteal, a stable ischemic situation, or a leg which is practically demarcated, compromised, or useless.

There are practical reasons for these rules. Most occlusions by far are arteriosclerotic and not embolic. Many acute occlusions improve spontaneously as collaterals open and enlarge. Many, perhaps most, occlusions are gradual and almost silent. The frequency of major vessel occlusions with minimal symptoms has been one of the more striking findings coming from the routine use of aortography in the evaluation of chronic circulatory problems. Arteriosclerotic vessels tend to develop useful collaterals unless they close very rapidly. Effective collateral vessels are usually not available in the younger population.

An acute arterial occlusion at a distal level, say popliteal or beyond, is unlikely to benefit from emergency arteriography or surgery unless (1) very recent (2) embolic, and (3) located in a relatively healthy vessel. An exception here is a ruptured popliteal (or femoral) aneurysm, which is always a surgical emergency if the limb is to be preserved. These aneurysmal vessels are different anyhow (see below). The more proximal the occlusion the more successful the surgery. This holds true even for patients with arteriosclerosis. Here also, indications for emergency surgery are limited however. No one would electively defer surgery on an aortic or iliac artery embolus. On the other hand, the occasionally seen massive aortic thrombosis cannot be treated in any fashion.

Angiography or surgical intervention in the barely viable limb during the acute phase can be the last straw. Most elderly patients with acutely symptomatic occlusions that any treatment could help, will improve on bed rest and heparin therapy. After collateral has had a week or two to develop, aortography and surgery will more likely be well tolerated.

### TRAUMATIC ARTERIAL OCCLUSION

The acute major artery occlusion in the young is generally post-traumatic or embolic, and requires emergency surgery. Traumatic arterial occlusion can be due to sharp or blunt injury. The sharp injury is usually more obvious although there may not be massive bleeding. Apparently minor blunt trauma may lead to occlusion, as in one case where a teen age boy walked into the tail fin of an automobile, bumping his femoral area.

I have often heard of post-traumatic spasm

leading to a complete loss of local and distal pulses, but I have never seen this. I believe that almost any injury resulting in a loss of distal pulses warrants early exploration. Findings at surgery are almost always the same. The injured vessel feels clotted but the lumen occlusion turns out to be secondary to a subintimal hematoma. A progressive intraluminal thrombosis can follow. As mentioned previously, heparin therapy after arterial surgery is dangerous and almost never indicated. This is because bleeding is much more likely than thrombosis after a reasonably satisfactory reconstruction. No experienced vascular surgeon would knowingly even consider a patient with thrombocytopenia or other bleeding tendencies for arterial reconstruction, because normal clotting is essential to arterial surgery.

### LEVEL OF ARTERIAL OCCLUSION

To help ascertain the level of arterial occlusion in an acute episode it is helpful to know what pulses were previously present. Lacking this information one may have to guess, using the opposite limb for comparison. The ischemic level is always distal to the level of occlusion, as nutrition at any level is delivered by small arteries derived from more proximal major branches. It is helpful to remember that emboli usually stick in narrowed areas such as the aorto-iliac bifurcation. Surgically significant atheromatous disease is also most common at these sites.

Prior to operation on any diseased vessel it is important to know if other vessels in the area are involved. For this reason I do trans-lumbar aortography preoperatively on all patients with chronic vascular insufficiency of the legs. It turns out that a **symptomatic** arteriosclerotic occlusion of the femoral artery is almost always associated with marked aorto-iliac occlusive disease. In fact a chronic arteriosclerotic femoral occlusion usually does not get symptomatic unless there is also proximal obstruction. This can be demonstrated by surgical correction of the aorto-iliac disease only, which results in the patient becoming asymptomatic. Aorto-iliac surgery has become my usual approach to a patient with both aorto-iliac and femoral arteriosclerotic occlusions.

Some schools however do mostly femoral arteriograms. It is true that one can frequently relieve symptoms in patients with femoral occlusive disease by bypassing much of the femoral artery, preferably by use of a long saphenous vein bypass graft. But even with saphenous vein grafts the failure rate is higher than after aorto-iliac surgery.

All arterial bypass operations have the same disadvantage when compared with accurate reconstruction (endarterectomy). That is they deliver a relatively high volume flow past a diseased vessel. This results in a reduced pressure gradient along the old artery. The smaller capacity line in such a parallel circuit, that is the arteriosclerotic trunk and its collaterals, then will tend to close and thrombose. Consider also that small vessels with low flows and long channels clot more easily, and remember that any incision on an ischemic limb will cut some functioning blood vessels. One can now see the advantage of a procedure which will deliver blood at a higher pressure to the entire vascular bed. One can also see why thrombosis of a bypass graft in the thigh can result in a situation more ischemic than before surgery, or even limb loss. The better long term results seen with an attack on the most proximal significant occlusion can therefore be explained.

**TRANSLUMBAR SYMPATHECTOMY** has been alternately overapplied and maligned. Prior sympathectomy appears to protect a limb from critical spasm during an acute episode of vascular occlusion. Sympathectomy is frequently combined with aortoiliac surgery and adds little to operating time or risk. I feel that translumbar sympathectomy by itself has been useful in the management of some patients with chronic vascular insufficiency when vascular surgery was not feasible.

There are many ischemic limb situations in which vascular surgery has little to offer. If angina is severe, intermittent claudication may not be a bad way to limit activities. When a limb is of no use, or when associated conditions will limit surgery or recovery, vascular surgery should not be encouraged.

### RENAL VASCULAR HYPERTENSION

No discussion of abdominal aortography for vascular disease is complete without a mention of the renal arteries. When hypertension presents in the first four decades, or is progressive and severe, evaluation of the renal arteries by aortography should be considered. This of course is particularly true if the patient is felt to be a candidate for surgical intervention. The most sophisticated and modern renal function tests can only suggest renal artery narrowing. A final decision on arterial pathology and surgical treatment can only be made after aortography. An IVP before aortography is often worthwhile for renal



evaluation. If desired however, one can obtain a good IVP on films taken just after translumbar or retrograde aortography.

The best results with surgery for renal artery hypertension are seen in conditions such as proximal artery fibromuscular hyperplasia in the younger patient. On the other hand the older patients with renal arteriosclerotic occlusive disease tend to have a poor prognosis with or without renal artery surgery. In fact there is a tendency to shy away from renal artery surgery in the elderly in centers where this was formerly promoted.

### CAROTID ARTERY SURGERY

Reconstruction of carotid and vertebral vessels is now possible, but the indications are not yet completely clear. It is generally agreed that the patient with multiple small or transient strokes should be evaluated for surgery. Also it now appears that the patient with a severe and progressing stroke is in a high risk category with or without surgery, although even here excellent results can occasionally be obtained. Generally the extreme variability of clinical course seen in different stroke patients makes one hesitate to recommend routine angiographic evaluation for carotid surgery in the elderly stroke patient. Interestingly enough angiographic localization of the lesion has somewhat discredited the diagnostic accuracy of the neurological examination.

Prophylactic vascular surgery for the asymptomatic patient is an area of disagreement at present. For example, should the asymptomatic patient with a carotid bruit have an aortic arch angiogram and possibly carotid surgery? At present I do not believe this warranted. Hopefully studies presently in progress will soon provide more information on this subject.

### ANEURYSMS

Little need be said about abdominal aneurysms except that they are likely to rupture. About 50% of untreated patients with abdominal aneurysms will die within two years of diagnosis. Surgery is now quite standardized and safe, with a mortality rate in our Iowa series of well under 5% for elective resection, but over 40% for emergency surgery. Aneurysmal changes also are apparently arteriosclerotic in nature. Interestingly enough, however, the entire associated arterial tree is usually not only patent but somewhat dilated.

Possibly also of interest is the marked chronic

perivascular inflammatory response so often seen at surgery for chronic arteriosclerotic occlusive disease. These patients often have arteries closely adherent to the surrounding tissues. I will leave these observations for the internist to contemplate.

One other observation should be emphasized. Almost all surgeons who frequently reconstruct arteries have become convinced that premenopausal oophorectomy and cigarette smoking are both major factors promoting precocious atherogenesis. Heavy smokers and female castrates (as well as many diabetics) have vessels which appear 15-20 years older than those of their non-smoking cohorts. Clinically, cigarette smoking is also closely related to both venous and arterial thrombotic conditions.

### CONCLUSIONS & SUMMARY

Acute major venous obstruction as in ileo-femoral thrombophlebitis always causes a swollen limb. Acute arterial obstruction never does. There are definite indications and contraindications for both surgery and heparin therapy in such acute situations.

Vena caval ligation should be reserved for patients who develop pulmonary emboli while on an adequate anticoagulation program, and for patients with an uncontrolled septic pelvic phlebitis.

Chronic vascular insufficiency of the lower body, whether at the Leriche level or in the calf, should always be evaluated by translumbar aortography prior to vascular reconstruction. If surgery is applicable the most proximal obstruction should be attacked first. This usually means an aortoiliac endarterectomy or bypass.

Sympathectomy is a useful adjunct to vascular surgery and sometimes offers the only possibility of palliation. A patient with an elevated cholesterol, or a patient who smokes, is not usually a satisfactory candidate for vascular surgery, unless the cholesterol level can be controlled by diet and the smoking is completely stopped. These factors promote atherogenesis and early reocclusion.

Cigarette smoking is known to increase blood coagulability and interfere with fibrinolysin activity. Clinically cigarettes appear to be implicated in many thrombotic disease processes. Atherosclerosis requiring surgical evaluation is unquestionably advanced by cigarette smoking, premenopausal castration, and hypercholesterolemia.



# NEW CARDIAC CATHETERIZATION LAB

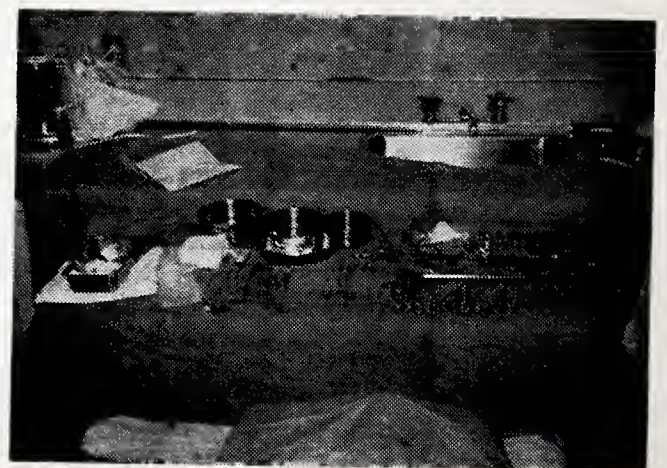
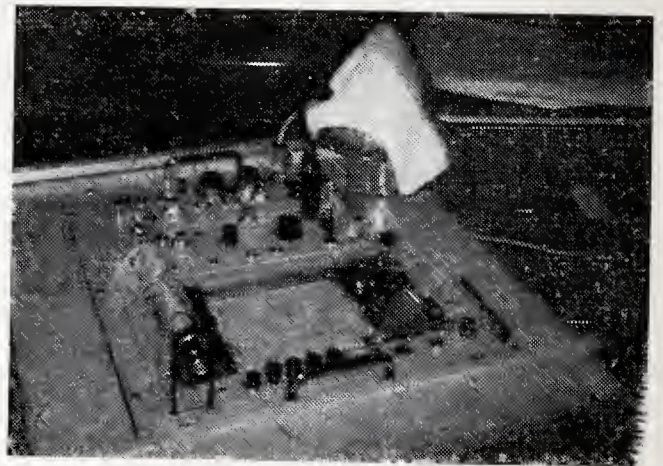
By Frederick R. Hood, M.D.  
and Arndt von Hippel, M.D.

The cardiac catheterization laboratory at the Providence Hospital has now been in operation for about six months. Equipment includes an image intensifier, a rapid film changer and pressure injector for angiocardiology, Sanborn pressure measuring and recording equipment, and Instrumentation Laboratory equipment for pH and gas analysis.

Diagnostic or preoperative studies have been done on patients with mitral or aortic valvular disease, patent ductus arteriosus, and atrial septal defect. In several cases surgery was found unnecessary or performed elsewhere on the basis of these studies. The patient with the patent ductus arteriosus had his diagnosis established and repair performed in Anchorage.

In the next year we hope to install Cine or T-V video equipment. This will finally make coronary arteriography available in Alaska. Coronary artery visualization for localization of the ischemic area is necessary before surgery is considered. Effective procedures are available for myocardial revascularization, in particular internal mammary implantation, and can now be performed in Alaska.

Coronary angiography has been indispensable in evaluating the efficacy of the various surgical approaches to coronary artery disease. It has also been of assistance in the diagnosis of coronary artery disease by providing a source of objective data in addition to the ECG. Frequently Cine coronary arteriography can establish the presence of significant coronary disease. On the other hand normal arteriographic findings offer substantial support for some other etiology of the symptoms.





## PRESIDENT'S PAGE



Robert H. Shuler, M.D.

The 1967 Convention of the Alaska State Medical Association, as you know, will be in Sitka this year. The dates will be from June 7th to 10th inclusive. The general theme of the convention will be "Common Complaints." This does not mean we will have common speakers or programs, but that generally, the speakers will be requested to bring things down to the level of practical application.

It is my belief that more participation by our own members should be encouraged in the scientific sessions. Please, if you have any kind of scientific paper in mind, or in preparation, let us know. Programming should be complete by April 1, so our speakers can be given an exact schedule.

We plan to have Mr. Roger Connor, an Alaska attorney with much experience in medical-legal cases, and one of the west coast's outstanding forensic pathologists, Doctor Charles P. Larson. Since the medical liability insurance problem is so important now, I have asked these speakers for contributions to our practical knowledge of "Preventative Legal Medicine." It won't be dull!

A few innovations in mind . . .

1. A clam and crab feed on Tuesday evening, June 6th, for those who arrive early (hot dogs also, if you must.)
2. I'm inviting any convention-goer who plays a musical instrument (portable type) to bring it along and we'll try a combo of our own for a dance after the ASMA Banquet.

Robert H. Shuler, M.D.

*President Alaska State Medical Association*

3. Wives of the exhibitors will be specifically invited to attend all of the Auxiliary events except business sessions.
4. As nearly as possible we'll try to arrange the scientific sessions in blocks or separate days (Surgery; OB-GYN-Peds; Medical & General) so those who want to enjoy Sitka's beautiful surroundings can plan accordingly. Let's face it—when we go to conventions away from home, we don't usually attend all the scientific sessions, so why not make things convenient? We'll have a fishing and sight-seeing committee, naturally.

This year we will make a valiant attempt to keep the business sessions short, and to avoid prolonged discussions of resolutions on the floor. We will try to have two resolution reference committees with time for separate hearings and have resolutions in final form at the general assembly sessions. **FOR THIS PURPOSE, ALL RESOLUTIONS SHOULD BE SUBMITTED BY MAY 1 TO THE OFFICE OF THE EXECUTIVE SECRETARY, preferably worded in clear, concise form.** We will keep pushing each local society from now on, but members at large should also remember to put their thoughts on paper early. **New resolutions will not be accepted after the first day of the meeting except by unanimous vote of the full assembly.**

You will receive an annotated copy of the ASMA budget a month before the meeting. This also should save time in discussion in the general assembly meeting.

By Council action November 5th, the traditional reports from Federal and State agencies will be eliminated, and if possible, these reports will be presented in ALASKA MEDICINE.

If you do plan to attend the convention, particularly by driving to Haines or coming through Skagway, make reservations on the Alaska Ferry System as soon as possible. If you do drive, unless you intend to go on south from Sitka, I'd suggest you leave your car at Haines or Skagway. There will be little need for your auto in Sitka, and you can buy a lot of cab fare for the shipping expense; besides which I understand the auto transportation is on a first-come, first-serve basis, with no implied guarantee even though the auto fare is paid in advance. Anchorage members and detail men might think about a charter flight direct to Sitka's new airport.

The new Centennial Center in Sitka will be finished in time for the convention and will be a fine, centrally located place for a good show.

**WELCOME TO SITKA IN '67.**



### AUTO TRANSPORTATION POSSIBILITIES TO SITKA FROM NORTHERN ALASKA FOR ANNUAL ASMA CONVENTION

Only direct Ferry to Sitka leaves Haines 10:30 AM June 5th—arrives Sitka  
11:55 PM June 5th.

#### Ferry and Plane Connections to Sitka

June 6th	Depart Haines (ferry) .....	11:55 PM	
	Arrive Juneau .....	6:00 AM	June 7th
	Depart Juneau (Alaska Coastal Airlines) .....	9:15 AM	
	Arrive Sitka .....	10:15 AM	
June 7th	Depart Haines (ferry) .....	10:30 PM	
	Arrive Juneau .....	4:00 AM	June 8th
	Depart Juneau (Alaska Coastal Airlines) .....	9:15 AM	
	Arrive Sitka .....	10:15 AM	
	Ferry Return to Haines from Sitka		
June 10th	Depart Sitka .....	8:45 AM	
	Arrive Haines .....	1:30 AM	June 11th
June 11th	Depart Sitka .....	9:15 AM	
	Arrive Haines .....	2:00 AM	June 12th

### AIR TRANSPORTATION POSSIBILITIES TO SITKA FROM ANCHORAGE FOR ANNUAL ASMA CONVENTION

#### Plane Connections to Sitka

June 6th	Depart Anchorage (Cordova) .....	10:00 AM	
	Depart Anchorage (PNA) .....	7:00 AM	
	Arrive Juneau (Cordova) .....	3:25 PM	
	Arrive Juneau (PNA) .....	12:05 PM	
	Depart Juneau (Alaska Coastal Airlines) .....	2:00 PM	
	Arrive Sitka .....	3:00 PM	
June 7th	Same as June 6th		

#### Return to Anchorage—Plane

June 10th	Depart Sitka (Alaska Coastal Airlines) .....	9:30 AM	
	Arrive Juneau .....	10:30 AM	
	Depart Juneau (Cordova) .....	5:00 PM	
	Depart Juneau (PNA) .....	1:15 PM	
	Arrive Anchorage (Cordova) .....	6:20 PM	
	Arrive Anchorage (PNA) .....	1:50-3:05 PM	
June 11th	Same as June 10th		

AIR TRANSPORTATION IS SUBJECT TO CHANGE. MORE DEFINITE  
INFORMATION WILL BE FORTHCOMING.





# ALASKA Medicine

Volume 9, Number 2

June 1967

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Nausea & vomiting	●		●
Neurological disorders	●		
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I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosage (in rare instances, may persist); weight gain; miosis; lactation and moderate breast engorgement (in females on high dosages); and less frequently cholestatic jaundice. Side effects occurring rarely include: mydriasis; agranulocytosis; skin pigmentation, lenticular and corneal deposits (after prolonged substantial dosages).

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# PRESIDENT'S PAGE

1967 may mark a turning point for ours and perhaps for many other State Medical Society memberships as well. For the first time, a law exists which takes a positive attitude toward proof of malpractice, and also instructs courts and juries to make their evaluations on that basis. Alaska is the only State at present with such a law on the books; we hope that others will follow suit.

This was a wonderful accomplishment, but how was it done? It took special efforts by many of our members; a willingness to spend money even if we had to dig into our savings (even Dr. Bob Wilkins was pried loose from the "building fund"); cooperation with knowledgeable attorneys; time for a trip to Juneau by Dr. St. John, Dr. Rod Wilson and myself. It took the cooperation of our three Doctor-Legislators; plus the political know-how of Attorneys Delaney and Doogan. It took compromise with members of the legislature on other matters. It took the efforts of a publicity agent whose grasp of the situation was unquestionably brilliant. Above all, it took the willing cooperation of the Alaska Dental Society, who had as much at stake as we, and were smart enough to see it in advance even though they weren't in a back-to-the wall situation. They told me that this was the first time they had been invited to participate in a conjoint effort. When I invited them to join our "planning breakfast" in Anchorage, I knew that the attitude of many of our members was: "Let 'em fight their own battles"; but I also knew that the Dental Society had grasped the need for positive political action better than we, and shown it in their lobbying during the past three or four years. Without their help, we'd probably be still waiting for action on S. B. 142!

Why bring this up?? Because it points the

way for future action which will be even more important to our lives as physicians. We cannot accomplish anything by censure versus understanding. Far too many of us, (with a psychological reaction that we above all others should be able to evaluate objectively) could think only of striking out at the legal profession. From all sides came the ringing call: "Let's fix those &\*&###¢ lawyers so they can't collect so much money from these cases, then maybe they won't be so anxious to crucify us". Memory is short, indeed! In 1965 and 1966, in our conventions, we passed resolutions which set our fees at the rates we thought best. We refused, by golly, to let any agency or group tell us what our charges should be!

We face more problems in the near future. As yet, Alaska legislation hasn't implemented any of the necessary laws for Title XIX of Medicare which must be on the books by 1970, or the State can be refused all Federal grants dealing with Health, Education and Welfare. Instead of destroying our own public image and chances for the respect of our own patients, even our own families, we'd better be willing to work, to cooperate, even though we feel the whole concept is abominable. WE MUST WORK WITH THE LEGISLATORS IN THE NEXT TWO YEARS TO PREPARE AN ACCEPTABLE PLAN, OR BE WILLING TO HAVE A FAR LESS ACCEPTABLE ONE FORCED UPON US. Remember, it was compromise, understanding and cooperation which enabled the ASMA to persuade, not force, our legislators to write the 1967 Malpractice Act into law. Let's keep on being Alaska pioneers, and accept our new role as physicians to society as well as to the individual.

It's unusual, perhaps, to thank someone



for handing one a tough job, but I do want to thank you for the worry, expense and extra work of this year as your President. It's a magnificent way to learn more and more about the other guy, the other professions, the reasons for our present status. I hope I'll never be complacent again.

Dr. Bob Wilkins, your President for 1967-68, has already spent more time and effort for the ASMA than anyone I can name, as Secretary-Treasurer for many years. Please

thank him by giving him the same cooperation you've given me, and rejoice, rejoice with us because there'll be the able and enthusiastic assistance of our new Executive Secretary, Mr. Bob Ogden.

Sincerely,  
Bob Shuler

(you might say that the ASMA is riding on a Bob-sled these days!)



*Robert H. Shuler, M.D.*

# COMMISSIONER'S PAGE

By W. John Chapman, M.D.

*Commissioner*

*Department of Health and Welfare  
State of Alaska*

President Johnson has enunciated a changed concept of the Federal government's role in relationship to the States. Oddly, there seems to be little general awareness of the significance of this change of direction. In essence, the States will be expected to determine their own needs, develop programs, and establish priorities for programs without the interference and direction of the Federal government, which will function primarily as a resource for money, manpower, and consultation.

The new approach is characterized by block grants of money which the States may distribute to their programs, based on their own priority system and expend as they determine the need. This is in contrast to the former focus on category grants wherein Federal guidelines were supplied to each program and programs were tailored to meet the Federal requirements.

Needless to say, there are some controls placed on this new process. The Act provides a specific inducement to the States to plan comprehensively according to Federal guidelines in order to meet specific objectives. The Surgeon General is empowered to interpret the intent of Congress, and does so through the use of "guidelines." There is, in my opinion, the implicit - though unspoken - clear intention of the Federal government to intercede and impose its own programs and enforcement where it is legally able, if the States fail to rise to the challenge of self-

determination of their health programs insofar as they are open to Federal purview.

Johnson views this total process as "creative federalism." It was Secretary Gardner of the Department of Health, Education and Welfare, who first coined the term a number of years ago and applied it to a concept which has, in essentials, become what we see today.

Admittedly, this is an incomplete picture of this complex new social development, but one which should serve to focus attention on this change in Federal emphasis.

One of the most significant Acts of social legislation in the 89th Congress - and, in fact, in recent times - was the Act entitled "Comprehensive Health Planning Act of 1966," also known as Public Law 89-749. This Act is in keeping with the new Federal concept of "creative federalism," the effect of which is to prompt the State to take the initiative in the development of its own health programs. The Act stimulates comprehensive health planning which will tend to effect the best possible development and integration of all health resources - State, local, Federal, and private non-profit and profit-making agencies - for the promotion of the best possible level of health for Alaskans.

Our Alaskan Department of Health and Welfare is unique among the States in that it encompasses a very broad spectrum of social services, including the Youth and Adult Authority, Public Welfare, Public Health, and Mental Health Divisions. PL 89-749 presents



for us a particularly useful catalyst for planning since we cannot limit ourselves to comprehensive health planning, but must instead plan comprehensively beyond the limits of the usual concept of health in order to promote the total social and physical well-being of Alaskans.

Governor Hickel has designated the State Department of Health and Welfare as the official planning agency for the development of the potential of the Comprehensive Health Planning Act. The Act makes funding available for the creation of an Office of Comprehensive Planning in the State Department of Health and Welfare, as well as a Citizen Advisory Council to advise the Department in comprehensive planning. During the last session, the State Legislature passed Alaska Statute No. 270 which allows the formation of the Advisory Council required by this Act. It is interesting that "consumers" must constitute the majority membership of this Council.

Development of area-wide comprehensive planning agencies which will integrate their comprehensive plans with those of a State-wide nature is also envisioned and provided for by this Act. This will allow boroughs, for example, to develop comprehensive health plans with the aid of funding under this Act. Federal money will be available to local agencies through the State Department of Health and Welfare to promote their programs in keeping with a comprehensive plan for the State as a whole.

Funding for programs undertaken as part of the overall State plan will be made available on a block grant basis, as provided for under one section of the Act, thus giving the State freedom to channel the money according

to its own needs. This is distinct from the categorical grants of the past.

Another interesting provision of this Act is that it permits the exchange of personnel. For example, Federal health employees may be assigned for periods of up to 2 years to State agencies involved with health activities.

One important result of this Act will be the promotion of an effective mutual involvement in health and welfare planning with the Alaska Native Health Service and the Bureau of Indian Affairs. Plans and discussions leading toward the development of this cooperative involvement are now under way.

We view this legislation as a very welcome opportunity to develop self-determination of our health and welfare needs. We will look to the medical profession for ideas, suggestions, and involvement in all comprehensive planning. The medical profession cannot be excluded from any significant planning for the State of Alaska. We must develop a cooperative relationship in the best tradition of medical practice.

"Constructive statism" expresses our basis for development in the Department of Health and Welfare. We shall carry the ball in Alaska and look to the federal government for funding, manpower, and consultation. In short, we shall view the Federal government as our resource partner. This is the opportunity which we see in "creative federalism."

This represents the most exciting and challenging development in the field of health and welfare at the present. However, it is by no means the only development under way. I look forward to being able to discuss our plans and programs with you in future issues of Alaska Medicine. I hope that you will give me the benefit of your views and suggestions in return.

# LOCAL ANESTHESIA TOXIC REACTIONS

By Dr. James A. Fraser

In a momentous demonstration before the Ophthalmological Congress at Heidelberg in 1884, Karl Koler demonstrated the topical anesthetic properties of cocaine. Within a short period of 12 months the newly discovered drug was tested in every major clinic in the world, and the utility of cocaine as a topical agent was tried in every form of intervention in which the insensibility of exposed surfaces could be of benefit to man. Halstead and associates began work within one week of the arrival of Koler's paper, and that year performed the first premeditated nerve block by injection. In 1885 Corning performed the first spinal and epidural procedures. This is in great contrast to the very slow development of general anesthesia.

Numerous toxic reactions were soon seen, stimulating search for better agents. In 1904 Einhorn introduced Novocaine, the first syn-

thetic agent. A great number of other local anesthetic drugs have been produced since then.

The current classic reference test on local and regional anesthesia drugs and procedures is REGIONAL BLOCK by Moore; 4th Ed., 1965, Charles C. Thomas Publisher. It should be available to everyone performing block anesthesia procedures.

## CLASSIFICATION

At present there are about 10 generally available local anesthetic agents. Moore classifies them in groups according to chemical structure. If a patient is known to have a true allergic sensitivity to one specific drug, a local anesthetic drug of another chemical group may usually be used without producing a reaction.

		Average Maximal Dose*		Common Use
Chemical Name	Brand Name	for Healthy Adults		
Benzoic Acid Esters	Procaine	Novocaine	1000 mgm.	Infiltration & Spinal
	Tetracaine	Pontocaine	125 mgm.	Infiltration, Spinal & Topical
	Chloroprocaine	Nesacaine	1000 mgm.	Infiltration only
	Cocaine		100 mgm.	Topical only
	Piperocaine	Metycaine	1000 mgm.	Infiltration only
	Diethoxin	Intracaine	1000 mgm.	Infiltration only
Chemically unrelated compounds	Lidocaine	Xylocaine	500 mgm.	Infiltration, Spinal & Topical
	Mepivacaine	Carbocaine	500 mgm.	Infiltration, Spinal & Topical
	Dibucaine	Nupercaine	40 mgm.	Spinal only
	Hexylcaine	Cyclaine	500 mgm	Infiltration & Topical only

\* Within these dose levels and common use categories, approximately equal safety may be assumed.



A new agent, Propitocaine (CitanestR) has recently been introduced. It is chemically related to Xylocaine. Early reports from the literature indicate that it has a wide safety margin because of a high maximal dose limit and it may enjoy wide clinical use in the future.

Several hundred other caine type drugs have been discovered, but most are not used clinically. Many are neurotoxic, others have a very high incidence of toxic reaction.

TOXIC REACTIONS

Systemic toxic reactions may be due either to true allergic sensitivity or to high blood levels of the drug, and the latter probably accounts for over 99% of cases. These are commonly known as Cocaine Reactions. Cocaine has probably been the most common cause of local anesthetic reactions as the allowable maximal dose is quite small (See table). Moore lists a number of factors of practical importance which lead to high blood levels.

- 1. Intravascular Injection--This is the most obvious cause, and can usually be avoided by careful aspiration for blood at each injection area. These areas include the head and neck, epidural spaces, trachea and lung. The mucous membranes of the airway absorb drugs very rapidly. Indeed, absorption from the lung itself is almost as rapid as intravenous injection. Vasoconstrictor drugs decrease local blood flow and slow absorption. Therefore, when large doses are used, particularly in vascular areas, the use of a vasoconstrictor is frequently helpful.
- 2. Individual susceptibility--As with most drugs, some patients, particularly the debilitated and the elderly, detoxify drugs more slowly. The liver detoxifies most local anesthetic drugs.

Cocaine, however, is excreted unchanged by the kidney. If a drug is detoxified more slowly than normal, it will reach higher blood levels, and these blood levels will last longer. The sum of repeat doses should not exceed the maximal dose at one time. Maximal dose blocks may be repeated at a later time, when the effects of the first begin to wear off.

- 3. Excessive doses and concentrations--More concentrated solutions are absorbed more rapidly than an equal miligram dose in a more dilute solution.
- 4. Total weight of drug injected--The maximum doses of drugs in use must always be remembered and never exceeded.
- 5. Use of spreading agents--Hyaluronidase can cause a 40% increase in the absorptive area, increasing the rate of absorption similarly.

A number of tests to predict possible abnormal responses to local anesthetic drugs have been proposed in the past. They are not generally used today as they are not reliable. A good history is all important.

SIGNS AND SYMPTOMS

The signs and symptoms of systemic toxic reactions to local anesthetic drugs are summarized in the table below.

- I. Toxic Reactions in Normal Individuals
  - A. CNS effects
    - 1. Stimulatory
      - a. Cortex — excitement, nervousness, incoherent speech, convulsions
      - b. Medulla
        - (1) Respiratory — tachypnea, irregularity

- (2) Vascular — Increased blood pressure and heart rate
    - (3) Other — vomiting
  - 2. Depression
    - a. Cortex — unconsciousness
    - b. Medulla
      - (1) Respiratory — decreased
      - (2) Vascular — decreased blood pressure and heart rate
  - B. Peripheral Effects
    - 1. Cardiovascular
      - a. Direct on heart—bradycardia
      - b. Vascular bed—vasodilatation
- II. Abnormal Responses
  - A. Allergic reactions
    - 1. Skin—urticaria, etc.
    - 2. Respiratory
    - 3. Cardiovascular

$\left. \begin{array}{l} \text{Respiratory} \\ \text{Cardiovascular} \end{array} \right\} \text{Anaphylactic shock}$
- III. Reactions not due to the anesthetic agent
  - A. Psychomotor—fainting, etc.
  - B. Vasopressor effect.

All types of reactions may be encountered simultaneously to a varying degree in one and the same case, and the preponderant symptoms will determine the therapy. However, most reactions do follow general patterns. The reaction may be immediate or delayed in onset, depending on how rapidly the high blood level is reached. Early signs of CNS stimulation include restlessness, nervousness, agitation, apprehension, incoherent speech, nausea and vomiting, dizziness, blurred vision, twitching. Severe reactions progress, perhaps rapidly, to convulsions. In early stages the respiratory rate and excursion may increase, later become irregular, and in severe reactions apnea ensues. Like the respiratory signs, cardiovascular signs show an early increase in readings which may progress to a severe depression.

## TREATMENT

The initial treatment of any toxic reaction

to a local anesthetic drug, whether the manifestations be central nervous system or vascular, stimulation or depression, is oxygen. This is best administered by bag and mask or endotracheally. The metabolic rate of the brain is greatly increased under the influence of pharmacologic stimulation. Unless the oxygen supply is increased significant hypoxia will result, and increase the severity of the symptoms. After the oxygen is started, intravenous fluid administration should be started to aid possible further therapy.

If convulsions ensue, oxygen remains the first drug to use. Oxygen is also helpful in seizures from other causes. As mentioned above, the stimulated brain has an increased metabolic rate, and, in the presence of convulsions, respiratory exchange will be severely decreased. If this does not stop the convulsions, the choice of further drugs will depend on the knowledge of the person in charge and the equipment available. The treatment of choice is the muscle relaxant succinylcholine (Anectine, Quelicin) 40 mgm. intravenously. This will completely paralyze all skeletal muscle for three to five minutes, so that optimal manual ventilation is necessary. If succinylcholine is not available, then Pentothal (Thiopental) in 50 to 100 mgm. doses, given in intervals of one to three minutes, may be used to stop the convulsions and allow oxygenation. Large doses of barbiturates significantly deepen the depression of the brain centers that follow convulsions.

Convulsions, caused by local anesthetic reactions, which do not respond to the above treatment are rare, but require very vigorous treatment. General anesthesia should be induced. This can be done by giving about 250 mgm. Pentothal and 4 to 7 cc d-tubocurarine intravenously, intubating the patient and ventilating with oxygen. If muscle relaxants are not available, inhalation anesthesia with Fluothane or Ether should be used. The Anes-



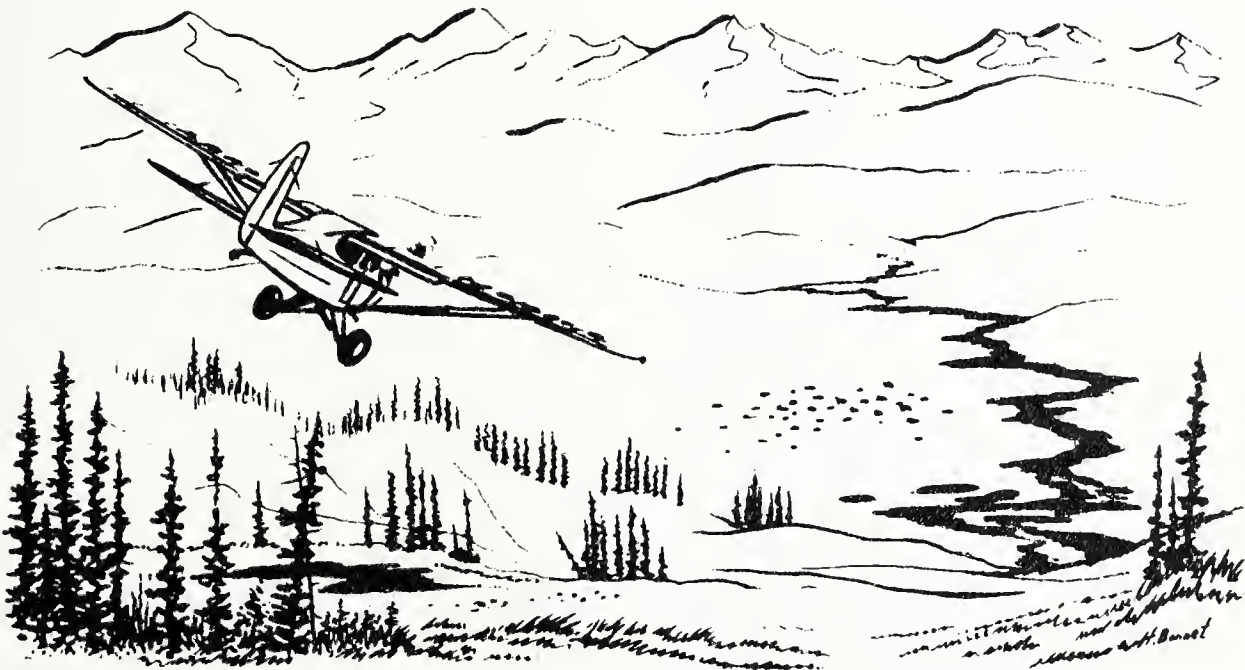
thesia may be lightened at 30 minute intervals until the seizures have ceased.

Adequate oxygenation will often stabilize the cardiovascular system. If hypotension ensues, an intravenous vasoconstrictor such as Neosynephrine (Phenylephrine) should be used. Cardiac standstill is more common than ventricular fibrillation, assuming oxygenation has been adequate and should be treated with cardiac massage and the usual cardiac drugs.

#### TRUE ALLERGIC REACTIONS

True allergic reactions to local anesthetic

drugs are very uncommon, probably causing less than one percent of all local drug reactions. Contact dermatitis frequently affects people who administer these drugs. This is an important reason why gloves should be routinely worn when handling these solutions. Generalized systemic allergic reactions may also occur, and cause angioneurotic edema, urticaria, arthralgia, asthma, G. I. upsets, and true anaphylactic shock. Treatment of these may require Benadryl, Adrenalin, Hydrocortisone, and Aminophylline in the usual doses.



# PHENYLKETONURIA

**By Irma W. Duncan, Ph. D.**

*Arctic Health Research Laboratory  
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Chairman, Governor's Advisory Committee  
for Mental Retardation*

Note: The following information about phenylketonuria (PKU) has been prepared at the suggestion of the Governor's Advisory Committee for Mental Retardation Program Planning in the belief that readers of ALASKA MEDICINE are interested in having more detailed information on this condition.

During recent decades knowledge about inherited diseases which lead to mental deficiency or other serious illness has advanced markedly. By August 1966, 34 states including Alaska had enacted legislation concerned with screening programs for phenylketonuria (PKU)<sup>1</sup>, a rare inherited disease which, if not treated in infancy, usually results in mental retardation.<sup>2</sup> Although the Alaska law was passed in April 1965,\* it has not been fully implemented, largely it is believed, because of a lack of understanding of the underlying factors.

Phenylketonuria was first recognized as an inherited disorder of phenylalanine metabolism in 1934 by Fölling, a Norwegian physician. Treatment did not become available until two decades later.<sup>2</sup> The reported incidence of PKU is 1 in 8-10,000;<sup>3</sup> however, the results of some recent screening programs indicate that the incidence may even be as high as 1 in 5,000.<sup>4</sup> Incidence is the same among Europeans, Americans and Japanese but lower among Jews and Negroes.<sup>5</sup> At present, approximately 1% of those institutionalized for mental retardation have this disease.<sup>6</sup>

Since phenylalanine occurs in all natural protein foods, the ingestion of proteins will cause phenylalanine as well as the other amino

acids to appear in the blood. In the normal person, most of the phenylalanine is converted to tyrosine by an enzyme normally in the liver. An individual with phenylketonuria (a phenylketonuric) lacks this enzyme and therefore lacks the ability to convert the amino acid phenylalanine into the amino acid tyrosine. In a phenylketonuric, phenylalanine and related substances rise to higher levels in the blood than in normal persons; these substances are excreted in the urine. One of these abnormal substances is phenylpyruvic acid which belongs to a class of compounds called ketones; hence the name, phenylketonuria.

Since the level of phenylalanine does not increase until after absorption of a protein meal, testing the infant at birth will not reveal the enzyme deficiency. However, in the infant afflicted with PKU, phenylalanine will rise above normal levels in his blood within 24 to 48 hours after the starting of milk feeding.<sup>7</sup> The resultant chemical environment of the developing brain is so altered that normal development does not occur; the reason for this is not known at present.

Timing of Screening Tests--The phenylalanine in the blood may be higher for some days, even weeks, before phenylpyruvic acid or phenylalanine will be detected in the urine. Therefore screening tests on infants under 4-6 weeks old should be done on blood samples. Since the early weeks of life are a very im-



portant period for brainmaturation, early diagnosis and treatment are essential.<sup>3,5,7</sup>

Caution must be used in interpreting the screening tests. A diagnosis of PKU is not made and treatment is not started until results of the blood tests have been confirmed by another method.<sup>2</sup> About 1 in 2,000 infants three to five days old will have a phenylalanine blood level considered intermediate between normal and grossly abnormal levels.<sup>2</sup> This rise may be transient or it may be confirmed by a later test. Such transient rises are often observed in premature infants. Some of the PKU infants may have ingested such small amounts of milk before their discharge from the hospital that the blood phenylalanine at the time of testing will be normal. A follow-up test at approximately one month should be performed to confirm the results of the earlier test.

Methods of Screening--Phenylalanine may be determined by chromatography, by a chemical method using a fluorometer,<sup>9</sup> or by the bacterial inhibition test (Guthrie)<sup>10</sup>. Chromatography is generally not used where large numbers of samples are involved. The bacterial inhibition test is simple, inexpensive and reliable.<sup>11</sup> Special paper is saturated with several drops of blood from a finger or heel prick. A disc of standard size (about 1/3 inch) is punched from the dried blood-soaked paper. The use of such a disc measures the same amount of blood in each test and allows the results to be reported as the weight of phenylalanine per a standard volume of blood. The blood discs and additional discs impregnated with various known amounts of phenylalanine are placed on a solid culture medium, which contains certain bacteria and a chemical which inhibits the growth of the bacteria, and incubated for 18 hours. Phenylalanine counteracts the chemical inhibitor and allows the bacteria to grow. The amount of phenylalanine present may be estimated by the extend of growth of the bacteria which

appears as an opaque white area or halo around the paper disc. The discs containing the known amounts of phenylalanine serve as standards for comparison.

The chemical analysis for phenylalanine by a fluorometric method is used to confirm any sample considered abnormal in the screening. This method is also used for screening and may be more widely used as automated methods become practical.

Who Does the Screening--In most of the heavily populated states the screening is done by personnel of the State Health Department Laboratory.<sup>1</sup> In 4 or 5 states private hospitals, designated by the state as regional centers, perform the tests.<sup>1</sup> Generally only a large laboratory will perform a large enough number of tests with above normal levels of phenylalanine to acquire skill in reading the results. Mailing of the blood-soaked paper discs has proved satisfactory.

The urine test for phenylpyruvic acid is simple; it may be performed by a nurse in the doctor's office and may also be used by the parents at home for monitoring of diagnosed cases. A green color is produced when ferric (iron) chloride is added to the urine or when a paper impregnated with a ferric salt (Phenistix) is dipped in the urine. This test is useful for the screening of adults and children over 4 weeks old.

Treatment--The treatment for PKU is to eliminate from the diet almost all of the phenylalanine. Since all natural protein foods are good sources of phenylalanine and protein is essential in the diet, the main part of the PKU diet is synthetic. This synthetic diet is usually prepared from a hydrolyzed casein treated to remove the phenylalanine and then fortified so as to provide an adequate protein diet except for the phenylalanine.

Since phenylalanine is an essential amino acid a certain low level must be maintained in the blood or symptoms of malnutrition will appear.<sup>5,12</sup> The child must have very small

amounts of milk and other proteins for adequate development. He may also have fruit, some vegetables, some cereals, sugar and starch. Water is added to the synthetic part of the diet and this is used as one would use milk. A baby usually accepts this formula. The diet is not difficult to administer during the bottle feeding stage but it is difficult to maintain when the toddler is able to forage for himself. If treatment is started early, the child may be expected to develop normally. Dietary treatment instituted as late as age 2 may help, but the child will probably not be normal.<sup>11</sup> As the child gets older, the severe dietary restrictions may be relaxed.<sup>2</sup> Current experience indicates that a child may tolerate a normal diet by six to eight years of age. His chemistry remains abnormal but his brain can tolerate this after a certain stage of development has been reached. The treatment of PKU requires an expert, well-integrated team, composed of pediatrician, nutritionist, public health nurse, social worker and laboratory technician.<sup>13</sup> Hospitalization is usually unnecessary.<sup>6</sup> Treatment should be carried out in the home under supervision, where the parents may provide the affection, stimulation, discipline and security necessary for normal behavioral development.

Diagnostic Signs--There are no truly diagnostic physical signs of the disease. The newborn appears normal; his skin and hair are usually lighter than those of his parents. Eczema, seizures and extreme irritability often occur. The odor of the urine may be musty. If untreated by the time he is three to four months old the child's development may be noticeably slowed. By 2-3 years his intelligence, and sometimes his physical growth, is definitely below normal. Some children with PKU never learn to walk; many never learn to talk. While 10% of individuals with PKU who do not receive treatment may be only mildly retarded, and another 0.5% may be judged to have normal intelligence; the

great majority will need to be institutionalized.

The small percentage of those untreated PKU children and adults diagnosed as PKU individuals but who appear to possess normal intelligence is cited by some as evidence that the claims for the dietary treatment are not valid. However, reports comparing the intelligence of phenylketonurics treated from early infancy with that of late-treated siblings indicate that the majority of these treated soon after birth appear to be normal.<sup>11</sup> When a group of treated phenylketonurics is compared to a comparable group of untreated cases, the marked contrast in intelligence is an unquestionable validation for diet therapy.<sup>14</sup> Secondary pathological changes due to the diet have been shown to be due to an incomplete follow-up in the treatment program.<sup>15</sup>

The recognition of phenylketonurics with normal intelligence also indicates a need for testing adults, especially pregnant women. A woman afflicted with PKU may be delivered of a child not afflicted with PKU but who has suffered brain damage in utero because of the abnormal levels of phenylalanine and related substances in the mother's blood.<sup>16,17,18</sup>

A female baby who grows to normal adulthood through dietary treatment, may produce a baby who is not a phenylketonuric but who may be brain damaged unless the mother's blood phenylalanine is controlled successfully during pregnancy. The first successfully treated girls are now twelve years old.

Operation and Costs of Program--The cost of any program is of course important to the public. To date, experience in other states has averaged about fifty cents per newborn tested, including a follow-up test at 4-6 weeks.<sup>3</sup> Assuming an incidence of PKU in Alaska similar to that in other states and countries, a complete testing program may be in force for two years before one case is discovered. Even assuming that screening each newborn would cost the state \$1.00, the cost for these two



years of testing would be \$16,000 (8,000 births per year). Compare this to \$100,000 which is a modest estimate for the lifetime care of one individual institutionalized for mental retardation.

Although extensive testing and an effective program can be conducted without mandatory legislation, experience in other states has indicated that legal requirement of such tests is more likely to insure every child's "bill of rights" than a voluntary testing program. However, merely ordering screening tests by law does not guarantee an effective program. As emphasized earlier in this article, detection is but the first step in a long-term treatment program.

Since most infants are born in hospitals where appropriate screening tests can easily be performed, the program should be initiated in the hospital. Moreover case finding in the neonatal period facilitates the early inauguration of therapy. Because of the high cost of hospitalization and adequate care for other young children in the home, some mothers and babies leave the hospital sooner than three days after birth. Records of each child's feed-

ings may be consulted and the pediatrician and public health nurse alerted if the baby was discharged and the blood sample taken before enough feedings had been given to test the possibility of PKU.

Much remains to be discovered about phenylketonuria. The fact that our knowledge is incomplete does not mean that we cannot utilize to advantage the information we already have.<sup>19</sup> Utilization of screening tests, confirmation of any positive tests, a second test at about one month of age and careful monitoring of all for whom the special diet is administered promises greater hope than ever before for the mentally retarded. Techniques are already available by which it is possible to screen a bloodspot for a variety of inborn errors.<sup>20, 21, 22</sup> Other diagnostic tests require serum and/or urine samples.<sup>23</sup> These new techniques are not yet widely used for screening, but it is evident that development of a testing program in one area serves to stimulate research in other areas and spurs the development of community programs with broad preventive implications.

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\* (Laws of Alaska, Chapter 90, Section 1, Article 6).

# PKU DISCUSSION

In reading the article on phenylketonuria by Doctor Irma Duncan, at your request, I am impressed with the wealth of research and the bibliography that she uses to back up her reasoning. I am taking the liberty of enclosing a monthly bulletin put out by the American Academy of Pediatrics (April 1967) and have quoted a comment which does not have a bibliography behind it, but has a wealth of experience on the part of numerous pediatricians, to the effect that the mandatory PKU legislation is poor, primarily because it is based upon unwarranted medical assumptions.

H. R. 913 -- *A bill to amend the Public Health Service Act in order to promote the detection of phenylketonuria and other inborn errors of metabolism leading to mental retardation or physical defects.*

*In our view, this is a poor piece of legislation, one with noble aims, but based upon unwarranted medical assumptions. We do not believe that, at this time, we have sufficient knowledge concerning either the correct and early diagnosis of inborn errors of metabolism, nor their effective management, to warrant this kind of public health programming. The funds needed to support this legislation would be much better utilized to further research in this field.*

This same feeling is again expressed by Doctor Gellis in editorial comments in the Yearbook of Pediatrics for 1967. Unfortunately, the articles that Doctor Duncan cites come to different conclusions and it gets to be a matter of opinion rather than a scientific fact. Certainly we want to do all we can to

prevent any severe mental retardation that is as apparently preventable as that due to phenylketonuria. To this effect, most pediatricians have for many years tested the urine with ferric chloride, either by putting drops of this material on the diaper or by using the Phenistix in a urine sample or in the diaper at the six-weeks check. Though I have yet to find a case of phenylketonuria, I will continue testing every baby as long as I am in the active practice of pediatrics. When the state legislatures pass laws ordering testing to be done in the newborn nursery, the real problem above and beyond that of expense is the removing of the onus of follow-up and detection from the shoulders of the doctor who will continue the care of the child. The net result is more likely to be that babies will not be checked at six weeks or at four weeks, depending on the routines of various physicians, and that without a central authority checking on every newborn test and following up on every positive or suggestive newborn test, the few cases that might be detected may remain undetected until too late. There are so many detectable problems that could be uncovered in the newborn period that occur with greater frequency and with equal devastation to the individual child and with even more possibilities for correction, that it would seem that too much time, effort and money is being wasted on this relatively uncommon disease with variable success as far as treatment is concerned at the present time.

HARVEY ZARTMAN, M.D.  
Anchorage Pediatric Group



# PKU DISCUSSION (continued)

Thank you for allowing me to review the Article on PKU by Dr. Duncan.

While I have no special quarrel with the description of the biochemistry of the disease and its clinical features, there are several points which might be made regarding the proposed mass screening program. My thoughts are obviously those of a newcomer to Alaska, possibly with an inadequate knowledge of state-wide problems.

It would seem that the expenditure of large amounts of money to discover an occasional example of a very rare disease is disproportionate to its importance. Especially so since many mundane diseases, such as tuberculosis and measles, still are important in Alaska (and elsewhere, for that matter). Further, most doctors probably are adequately screening their patients within the limits that remoteness, lack of communications, and difficulty in follow-up impose. Legislation cannot solve these problems. Probably most children who do not receive a routine screening test for PKU do not because of their location, and so forth, rather than ignorance on the part of the local doctor. Of even more importance, however, is the experience of some workers in the field suggesting that mass screening programs are not working as well as had been expected. In a recent article in Medical World News, abstracted from the New York State

Psychiatric Journal, Dr. S. P. Bessman, of the University of Maryland, points out that many adults have been discovered with high levels of phenylalanine and normal intelligence, and many children of these mothers have normal phenylalanine levels but later develop the PKU syndrome anyway. Further, the incidence of high levels of phenylalanine in children is much higher than the incidence of the disease, showing again that the disease is not directly related to the chemical finding. He suggests that at least some of the apparent improvement in children with early mental retardation, and the lack of development of retardation in others may be more the result of increased attention and training than the amino acid deficient diet to which they are subjected.

It would seem that perhaps it might be prudent for Alaska to profit by the experience of others and at least await more encouraging results from elsewhere before embarking on this admittedly expensive program.

Donald R. Rogers, M. D.  
Director of Laboratories  
Anchorage Community Hospital



# FRACTURE CLINIC

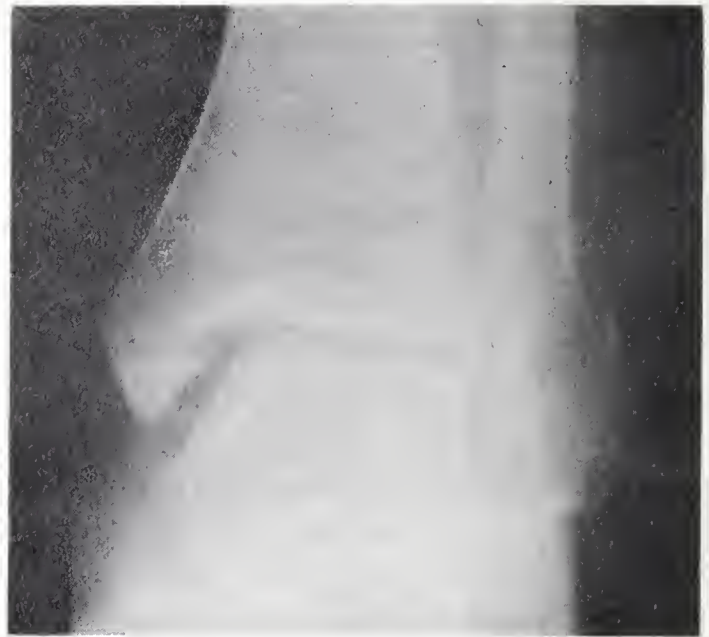
## Fracture of the Lateral Malleolus

By J. Paul Dittrich, M.D.

Fracture of the lateral malleolus of the ankle is a relatively common injury. It is produced by a lateral rotation stress of the foot, twisting the talus in a lateral arc with the anterior margin of the dome of the talus striking the inner aspect of the lateral malleolus, causing it to fracture just above the ankle joint. The course of the fracture line is remarkably constant in these injuries, beginning at the level of the ankle joint and running in a spiral fashion cephalad and laterally. (See Figure 1) If the stress is directed more into abduction, the fracture line may run in a more horizontal plane. Displacement is usually minimal, and treatment is simple. No reduction is necessary. A short leg walking cast for four to six weeks, or a light pressure dressing with non-weight bearing on crutches until pain and swelling subside, will invariably yield an excellent result.

It must be recognized, however, that this same external rotation force can cause a variety of ankle injuries, depending on the amount of force applied and which structures are damaged. In general, four situations may result, graded 1 through 4 in ascending order of severity.

- (1) With slight stress, the external rotation force is halted without fracture or significant ligament injury.
- (2) With greater force applied, the lateral malleolus may fracture, as described in the opening paragraph, but the stress is not sufficient to cause injury to the medial structures of the ankle. The x-ray shows normal alignment of the ankle mortise,



*Figure 1*

and there is very little if any tenderness and swelling over the medial aspect of the ankle.

- (3) With increased force, the talus may continue further into external rotation and, after fracturing the lateral malleolus, may, through the strong medial deltoid ligament, avulse the medial malleolus. This results in tenderness and swelling over both the medial and lateral aspects of the ankle, and is easily recognized on x-ray as the typical bimalleolar or Potts fracture. This injury requires anatomic reduction, either open or closed.
- (4) It is possible that instead of the medial malleolus being avulsed by the pull of the deltoid ligament, the ligament itself may rupture. As in the bimalleolar fracture, this results in an unstable ankle, but



is more likely to be missed, because the examination and x-ray findings are usually quite subtle. The important factor here is to distinguish this injury from Type (2), the relatively benign simple fracture of the lateral malleolus, as the treatment and prognosis are entirely different. Two clues are useful in distinguishing the two. First, if the deltoid ligament is ruptured, there will be swelling and tenderness over and distal to the medial malleolus. Second, the ankle mortise will show, or can be made to show lateral displacement of the talus in the ankle mortise, with asymmetry of the mortise. This asymmetry may be present on the plain A-P film taken with the ankle in 20 degrees of internal rotation. If not it may be demonstrated by an A-P film taken while an abduction-external rotation force is applied to the foot.

Is it necessary to take a stress film in every fracture of the lateral malleolus? No. This view need be taken only if there is in addition to the fracture of the lateral malleolus, tenderness and swelling over the medial aspect of the ankle and in that situation it is a necessity. If instability of the ankle is thus demonstrated, accurate reduction and prolonged immobilization for a minimum of eight weeks are essential. The following case is used to illustrate such an injury.

The patient is a 28 year old white male who slipped and fell on January 28, twisting his left ankle. He had immediate pain in the ankle and was unable to bear weight on it. The accident occurred in an outlying area, and the patient could not be evacuated until the following day. When seen on January 29, thirty hours after the injury, there was mar-

ked swelling and deformity of the foot. There was swelling and tenderness over the lateral malleolus. In addition, there was marked swelling and tenderness anterior and inferior to the medial malleolus. External rotation stress caused pain over both the medial and lateral malleolar areas. An x-ray was obtained (Figure 1). This illustrates the typical fracture of the lateral malleolus, but in addition and most important shows the asymmetry of the ankle mortise with widening of the joint space medially. This widening of the joint space medially can occur only if the deltoid ligament has been ruptured. Because of the marked swelling a pressure dressing was applied and the leg was elevated overnight. The following day, under general anesthesia the ankle was reduced by applying an inversion adduction force over the lateral malleolus and calcaneus. A short leg cast was applied in this position. Post reduction x-rays through plaster revealed satisfactory position and an ankle mortise that was symmetrical medially and laterally. No follow up is available on this patient as he elected to return to his home in California to convalesce.

Occasionally closed reduction of this injury will fail. This is invariably due to the torn edges of the deltoid ligament having become interposed between the articular surfaces of the medial malleolus and the talus. In this instance, open reduction with removal of the deltoid ligament from the joint space is imperative. At this time suture of the ligament and internal fixation of the lateral malleolus with an intramedullary pin would be advisable.

This injury should be held in plaster a minimum of eight weeks, and preferably ten to twelve weeks.

# ALASKA MEDICINE

## Through the Retrospectiscope

By Elizabeth A. Tower, M.D.

*Former Editor*

ALASKA MEDICINE came into being on the crest of the enthusiasm over statehood in 1958 and 1959. In May of 1958 at the last Territorial Medical Association meeting in Fairbanks, a committee was appointed to investigate the feasibility of publication of an Alaskan medical journal. At the first meeting of the Alaska State Medical Association in June of 1959, the committee report was presented in the form of the Vol. I, No. I (March 1959) issue of ALASKA MEDICINE. In the forward to the first edition, the Editor-In-Chief, Dr. William J. Mills, Jr., Anchorage orthopedic surgeon, waxed poetic in proclaiming "we are given the opportunity now to insure that no longer need the unrecorded medical voice be sent plaintively wailing across the waters of the Inland Passage, to quiver in the Susitna Flats, or be sent rumbling toward the peaks of Mt. McKinley, only to wither and be dissipated in the wilderness."

With the enthusiastic acceptance of this committee report, the "Rubicon was crossed" and ALASKA MEDICINE came into being. The second edition carried letters from Herbert Hartley, M. D., Editor of Northwest Medicine, with whom Alaska had previously been affiliated, congratulating ALASKA MEDICINE for having sprung "Like Athena -- complete in every detail"; from Joseph Garland, M. D., Editor of the New England Journal of Medicine, who honored ALASKA MEDICINE's birth in an editorial in his revered journal; from Johnson F. Hammond, M. D., Editor of the JAMA; and even from Bradford Washburn,

Director of the Boston Museum of Science, informing the editorial staff that his photograph used on the cover of the first edition was the North Face of Mt. Brooks, not McKinley as advertised.

In the early years Anchorage internists William O. Maddock, Robert D. Whaley, and Rodman Wilson served as working Editors. Classic articles on such Arctic oddities as botulism in muktuk, salmonella in sea gulls, and climbing Mt. McKinley, were plentiful; eye catching photographs of Alaskan scenes were contributed by physician photographers; and drug companies were eager to finance the journal through their advertising despite the limited circulation which resulted in as many copies of each issue going as exchange journals to other states as to any other category of subscriber. Exchange journals from other states flooded the editor's office, were projected as the basis for a State Medical Library, and eventually ended up stored in an antiquated two room log cabin.

In 1961, I took over the management and editing of ALASKA MEDICINE, complete with cabin full of its exchange journals, and continued to bear these dual responsibilities until 1966 when the office of the Alaska Medical Association was established in Anchorage with a full time Executive Secretary. Throughout these five years, ALASKA MEDICINE has always come out, often two months late and frequently undernourished both in scientific content and in advertising, but nevertheless it has come out and has weathered the storms



of a bankrupt printing house, a decrease in national advertising by drug companies, an earthquake and tidal wave. (The latter disaster was capitalized on with a special Earthquake Edition, which was published in June 1964, and was in such demand by civil defense agencies through the country that an additional special printing was required.)

Throughout the years the journal has been graced by articles featuring the history of medicine from the days of Steller and Bering (March 1967) through those of the Russian America Company (June and September 1962) and the Dogteam Doctor J. H. Romig (December 1963) to the present, and by an informative and amusing gossip column "Muktuk Morsels" compiled until the past year by Dr. Helen Whaley.

Dr. Arndt von Hippel has now taken over

the responsibilities of editorship and already the infusion of new blood is evident in the increased scope of the magazine. The business management carried on by Robert Ogden, the Executive Secretary of ASMA, is on a firm foundation. Good days should be ahead for ALASKA MEDICINE, but as before, the magazine will only be as good as the quantity and quality of the contributions by the physicians of Alaska. If they do not wish to have "the unrecorded medical voice... sent plaintively wailing across the waters of the Inland Passage...", they should commit it to writing and submit it to ALASKA MEDICINE! For my own part, I sincerely thank all of those who submitted articles while I was editor and urge them to so honor Dr. von Hippel. In the meantime, if anyone wishes to have copies of back issues, I still have an attic full of them!!



# NEW STATE LEGISLATION OF MEDICAL INTEREST

By Rodman Wilson, M.D.

In the recently completed First Session of the Fifth Alaska legislature several bills of medical interest were passed and signed into law by Governor Walter J. Hickel.

Of particular interest to practicing physicians and dentists was the medical "malpractice" bill (CSSB 142) which the Alaska State Medical Association proposed as a solution to the situation created by the *Patrick vs Sedwick* decision of 1964 by the Alaska Supreme Court (ref to March 1967 issue of *Alaska Medicine*) wherein it appeared that a defendant in a professional liability suit had to prove his innocence. Members of the Alaska State Medical Association with the help of counsel worked with great diligence and persuasiveness for the passage of the bill. Three physician members of the Association appeared at a hearing in Juneau on the bill. It is hoped that the new law will correct the situation and will encourage insurance carriers to offer liability insurance at reasonable rates in Alaska.

A "Good Samaritan" bill of broad applicability also was enacted into law. (SB 89)

Before Alaska law is entirely clear on this matter, however, a section of an existing statute (AS 08.64.365) which in a narrower fashion also applies to emergency care, needs to be repealed. Legislation to do this has been introduced (SB 198) and has been held over for consideration by the Second Session of the Fifth Legislature in 1968.

The overly restrictive statute (AS 18.15.200) concerning the testing of newborn infants for phenylketonuria was repealed and

re-enacted. The new law (CS 73) specifies that the Department of Health and Welfare shall provide tests, test materials, reporting forms and mailing cartons. Time of testing is not specified. A companion bill funding this new service of the Department of Health and Welfare has not yet been passed. Presumably the Department must provide the service within its existing budget.

Senate Bill 53 licensing psychologists was enacted. It creates a board of three psychologist examiners to pass on applicants for licensure. Psychologists holding a PhD degree in psychology who have had at least one year of experience and who are otherwise acceptable to the board are eligible for examination by the board. Licensure before January 1968 of psychologists with less than PhD qualifications is permitted for psychologists who have practiced at least one year in Alaska. At the present there are only about 10 psychologists in Alaska who come under the provisions of this act, but standards for licensing new psychologists are now set.

An act licensing agencies providing child placement and counselling services (HB 201) was also passed. This bill defines boarding homes, foster homes, institutions, and nurseries and requires their licensing. The act amends an older statute (AS 47.35.030).

HB 270, an act relating to the Alaska Comprehensive Health Advisory Council was enacted into law. This law brings certain earlier statutes (AS 18.05.051 and .053) into line with federal laws on the same subject and is of importance with respect to future decisions



by the State concerning Title 19 of the Medicare Act.

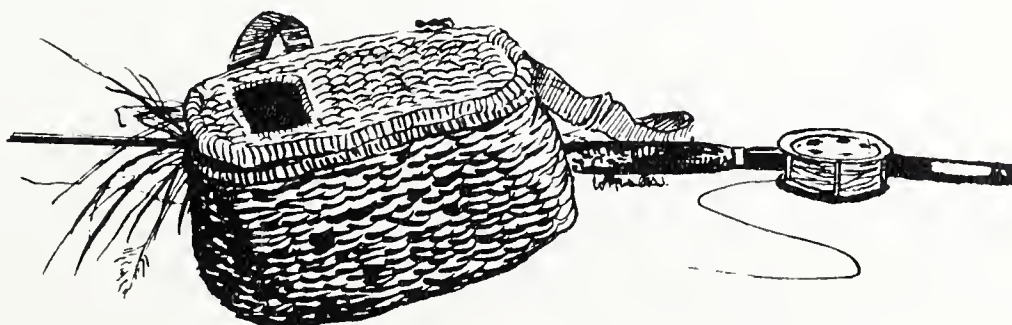
HB 329 expands the Alcoholism Advisory Board (AS 44.29.040) from five to nine members and specifies that one member have special interest and experience in the problems of alcoholism, that one member be a public health nurse, one a social worker, one an alcoholic, one a representative of the liquor industry, and one a member of the public at large.

HB 276, an act relating to premartial blood tests for syphilis, which are required in Alaska, amends existing law (AS 25.05.151) to allow, but not require the laboratories of the State Department of Health and Welfare to charge a fee for the test. If the Department decides to charge, then, presumably, private laboratories would be in a more favorable competitive position with respect to these tests.

Several resolutions were made by the Legislature. Among them were resolutions calling for the establishment by the U. S. Public Health Service of hospitals at St. Mary's, Andreafsky, and Unalakleet and for the establishment of a Bethel Premarital Home. HR 6, relating to the boundaries of responsibility of private and governmental agencies in the practice of medicine and dentistry, was also adopted. This is a matter which the Alaska State Medical Association may consider at the annual meeting in Sitka in June 1967.

Many other bills of medical importance are held over for consideration in the Second Session. Among them are acts relating to air pollution (SB 93, SB 163) information to be placed on drivers licenses (SB 10, HB 31), professional corporations (SB 80), sale and use of depressant and stimulant drugs (SB 146), standards for eyeglasses and sunglasses (HB 68), composition of the State Medical Board (HB 132), standards in the analysis of blood in prosecution of drunk drivers (HB 178), exemption of school physical examinations on religious grounds (HB 207), revision of the child abuse law to make reporting of incidents mandatory (HB 300), regulation of clinical laboratories (HB 327), and licensing of physicians (HB 338).

All in all 1967 was a fruitful year with respect to the passage of medical legislation. Alaskan physicians were fortunate to have among the sixty members of the Legislature three practicing physicians, Senator Haggland of Fairbanks and Representatives Fritz and Beirne of Anchorage. These men were instrumental in the introduction and passage of most of the bills and resolutions described above. The Alaska State Medical Association and component societies also had unaccustomed rapport with the other fifty-seven members of the legislature, with the Commissioner of Health and Welfare, and with the Governor. It is hoped that this climate of cooperation for the good of the health of Alaskans will continue in 1968.





Original Sponsors: Thomas, Smith, Palmer, et al. Offered 3/18/67. Referred: Health, Welfare and Education. In the Senate by the Judiciary Committee. CS for Senate Bill No. 53 in the Legislature of the State of Alaska, Fifth Legislature, First Session.

#### A BILL

For an Act entitled: "An Act relating to licensure of psychologists; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

Section 1. AS 08 is amended by adding a new chapter to read:

#### CHAPTER 86. PSYCHOLOGISTS

##### ARTICLE 1. BOARD OF PSYCHOLOGIST EXAMINERS.

Sec. 08.86.010. CREATION AND MEMBERSHIP OF BOARD. There is created a Board of Psychologist Examiners. It consists of three licensed psychologists.

Sec. 08.86.020. APPOINTMENT AND TERM OF OFFICE. Members of the board are appointed by the governor and confirmed by the legislature for staggered terms of three years. A member serves at the pleasure of the governor.

Sec. 08.86.030. BOARD MEETINGS. The board shall hold a regular annual meeting. The board may hold special meetings at the call of the chairman or of two board members.

Sec. 08.86.040. ASSISTANTS. The board may employ assistants to prepare and grade examinations and to investigate alleged violations of this chapter.

Sec. 08.86.050. TRANSPORTATION AND PER DIEM. Notwithstanding the provisions of AS 39.20, no board member is entitled to transportation or per diem allowances.

##### ARTICLE 2. ADMINISTRATION OF BOARD AFFAIRS.

Sec. 08.86.070. DUTIES OF THE BOARD. The board shall

(1) pass on qualifications of applicants for licenses;

(2) prepare, administer and grade oral or written examinations;

(3) after hearing, suspend or revoke the license of a licensed psychologist who violates a regulation of the board.

Sec. 08.86.080. BOARD REGULATIONS. The board shall adopt regulations to carry out the purposes of this chapter.

Sec. 08.86.090. ADMINISTRATIVE DUTIES OF THE DEPARTMENT. The department shall furnish administrative services for the board.

Sec. 08.86.100. APPLICABILITY OF THE ADMINISTRATIVE PROCEDURE ACT. The Administrative Procedure Act (AS 44.62) applies to regulations and proceedings under this chapter.

##### ARTICLE 3. LICENSING

Sec. 08.86.120. ENTITLEMENT TO LICENSURE. A person who passes the examination given by the board is entitled to be licensed as a psychologist.

Sec. 08.86.130. QUALIFICATIONS FOR EXAMINATION. A person is entitled to take an examination if the board finds he

(1) has not engaged in dishonorable conduct relevant to the practice of psychology;

(2) holds a doctoral degree with primary emphasis on psychology from an accredited school;

(3) has at least one year's experience acceptable to the board.

Sec. 08.86.140. FEES. Each application fee, renewal fee, annual and out-of-state license fees is \$15. The fee for a duplicate license is \$2.

Sec. 08.86.150. OUT-OF-STATE LICENSE. A person who is licensed or certified as a psychologist by an authority other than Alaska is entitled to be licensed in Alaska without examination if

(1) he holds a doctoral degree with primary emphasis on psychology from an accredited school; and

(2) the examination and qualification requirements for his out-of-state license or certificate were essentially similar to the examination and qualification requirements for licensure in Alaska at the time he was licensed; or

(3) he is a diplomate in good standing of the American Board of Examiners in Professional Psychology; and

(4) he completes and returns the proper application forms, and pays the out-of-state certificate fee.

##### ARTICLE 4. PROHIBITIONS AND PENALTIES

Sec. 08.86.170. USE OF TITLE. Unless he is licensed under this chapter, no person may use the title "psychologist" or any title, designation, or device indicating or tending to indicate that he is a psychologist or practices psychology.

Sec. 08.86.180. PRACTICE OF PSYCHOLOGY. (a) Unless he is licensed under this chapter, no person may practice psychology, offer to practice psychology, or represent to the public that he is a psychologist or that he practices psychology.

(b) This section does not apply to

(1) a person employed by a governmental unit or educational institution who may be required to engage in some phase of work of a psychological nature in the course of his employment;

(2) a student, intern, or resident in psychology pursuing a course of study approved by the board as qualifying training and experience for psychologist, if his activities constitute a part of his supervised course of study and he is designated by titles such as "psychology intern" or "psychology trainee";

(3) a qualified member of another profession, such as a social worker, or pastoral counselor, in doing work of a psychological nature consistent with his training and consistent with the code of ethics of his profession;

(4) a person describing himself as a "social psychologist", if he is verified to be a social psychologist by the American Sociological Society;

(5) a person practicing medicine, if he is licensed to practice medicine.

(c) Nothing in this chapter authorizes a person licensed as a psychologist to engage in the practice of medicine, as defined by the laws of the state.

Sec. 08.86.190. NAME UNDER WHICH PERSON PRACTICES. A licensed psychologist may practice psychology only under his own name.

Sec. 08.86.210. PENALTY. A person who violates sec. 170, sec. 180, or sec. 190 of this chapter is guilty of a misdemeanor.

##### ARTICLE 5. GENERAL PROVISIONS.

Sec. 08.86.230. DEFINITIONS. In this chapter

(1) "psychologist" means a person who practices psychology;

Introduced 2/23/67. Referred: Health, Welfare and Education. In the House by Fritz by request. House Resolution No. 6, in the Legislature of the State of Alaska, Fifth Legislature, First Session, relating to the practice of medicine and dentistry.

BE IT RESOLVED BY THE HOUSE OF REPRESENTATIVES:

WHEREAS the respective areas properly allocated to private and to government-sponsored practice of medicine and dentistry are ill defined; WHEREAS this causes unnecessary confusion;

BE IT RESOLVED that the Alaska State Medical Association and the Alaska State Dental Association are requested to clarify the boundaries between private and governmental responsibilities in the practice of medicine and of dentistry for the improved health of all Alaska citizens; and be it

FURTHER RESOLVED that the Alaska State Medical Association and the Alaska State Dental Association are requested to submit a report of their findings and recommendations within ten days after the convening of the Second Session of the Fifth State Legislature.

Original sponsor: Beirne. Offered 3/27/67. Referred: Rules. In the House by the Health, Welfare and Education Committee. CS for House Bill No. 276 in the Legislature of the State of Alaska, Fifth Legislature, First Session.

#### A BILL

For an Act entitled: "An Act relating to premarital laboratory tests."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

Section 1. AS 25.05.151 is amended to read:

Sec. 25.05.151. TESTS AND LABORATORIES. For the purpose of this chapter, a standard serological test is a test for syphilis approved by the department, made at a laboratory or clinic approved by the department. The department may make regulations under the Administrative Procedure Act (AS 44.62) governing the approval of laboratories or clinics for standard serological tests. The laboratories of the department may (SHALL) make required premarital laboratory tests without charge on the request of any licensed physician or surgeon. In submitting the sample to the laboratory the physician shall identify it as a premarital test sample.

Introduced 3/7/67. Referred: Health, Welfare and Education and Finance. In the House by Beirne and Fritz. House Bill No. 270 in the Legislature of the State of Alaska, Fifth Legislature, First Session.

#### A BILL

For an Act entitled: "An Act relating to the Alaska Comprehensive Health Advisory Council."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

Section 1. AS 18.05.051 is amended to read:

Sec. 18.05.051. COMPREHENSIVE HEALTH (FACILITIES) ADVISORY COUNCIL. (a) There is created a Comprehensive Health (FACILITIES) Advisory Council which shall consist of governmental and nongovernmental members.

(b) The council shall include 11 nongovernmental members, eight (SEVEN) of whom shall be consumers of health services and three (FOUR) of whom shall be representatives of nongovernmental agencies which (WHO) are concerned with health care services.

(1) Nongovernmental members are appointed by the governor subject to confirmation by a majority of the members of the legislature in joint session. Four members shall serve initial terms of two years, four members initial terms of three years, and three members initial terms of four years. Initial terms date from February 1 before appointment. Thereafter, terms of office are four years, unless the appointment is for the remainder of an unexpired term. Each member holds office at the pleasure of the governor notwithstanding the member's term.

(2) Nongovernmental members may carry out their duties on the council after appointment but before confirmation or rejection by the legislature.

(3) Nongovernmental members receive no salary but are entitled to per diem and travel expenses authorized by law for state boards. Nongovernmental members may receive travel expenses and per diem in connection with the exercise of their duties as council members before their confirmation or rejection by the legislature.

(c) The council shall include four governmental members: one (TWO) from the Department of Health and Welfare; one from the Department of Administration; one from a health agency of a local government unit; and the commissioner of health and welfare, are appointed by the governor. The commissioner of health and welfare shall act as chairman of the council, and his department shall administer the comprehensive state health service plan.

(d) The governor shall appoint two advisors to the council; one of whom shall be from the Department of Labor and one of whom shall be from the Department of Education who shall represent education and vocational rehabilitation.

(e) Additional members may be appointed under this section by the governor in compliance with (AS REQUIRED BY) federal law.

Sec. 2. AS 18.05.053 is amended to read:

Sec. 18.05.053. POWERS AND DUTIES. The Comprehensive Health (FACILITIES) Advisory Council shall

(1) advise and consult with the commissioner of health and welfare regarding

(A) programs for the construction of health facilities for the state and its political subdivisions;

(B) the development of rules, regulations, and standards for the operation of health facilities;

(C) the development of a comprehensive state health service plan, to be reviewed at least annually, and to be submitted to the Surgeon General of the United States for his approval;

(2) request the cooperation of governmental and nongovernmental agencies in planning and developing programs relating to the rehabilitation, education, employment, health and welfare of patients in health facilities;

(3) exercise the additional powers and perform the duties which are necessary to comply with appropriate (OBTAIN FINANCIAL ASSISTANCE UNDER) federal programs.

(2) "to practice psychology" means to apply established principles of learning, motivation, perception, thinking, and emotional relationships to problems of personal evaluation, group relations, and behavior adjustment, including

(A) counseling and guidance;

(B) using psychotherapeutic techniques with persons or groups of persons who have adjustment problems in the family, at school, or at work;

(C) measuring and testing of personality, intelligence, aptitudes, emotions, public opinion, and attitudes and skills;

(D) conducting research on human behavior;

(3) "board" means the Board of Psychologist Examiners;

(4) "department" means the Department of Commerce.

Sec. 2. AS 08.01.010 is amended by adding a subsection to read:

(15) Board of Psychologist Examiners.

Sec. 3. A person who applies for a license under this chapter before January 1, 1968, and who pays a fee of \$15 is entitled to a license without examination, if the board finds he

(1) has never engaged in dishonorable conduct relevant to the practice of psychology; and

(2) holds a doctoral degree with primary emphasis on psychology from an accredited school and has had at least one year of experience in Alaska in the practice of psychology following receipt of his doctoral degree; or holds a master's degree or its equivalent with primary emphasis in psychology from an accredited school and has had at least five years of experience, including one year in Alaska, in the practice of psychology following receipt of his master's degree or its equivalent.

Sec. 4. The governor may appoint to the initial board unlicensed psychologists who are eligible to be licensed under sec. 2 of this Act, and who will have practiced psychology in the state for at least two years before January 1, 1968.

Sec. 5. AS 39.20.180 is amended to read:

Sec. 39.20.180. TRANSPORTATION AND PER DIEM EXPENSES FOR MEMBERS OF BOARDS, COMMISSIONS, ETC. Except as otherwise provided by law, from and after March 27, 1962, the provisions in this section relating to per diem and transportation govern exclusively and supersede all other provisions of law with respect to a member of a state board, commission, committee, judicial council, or other similar body of persons of the state organized or established under the authority of law, but excluding any other state employee other than a legislator, who is otherwise entitled by law to receive from the state payments for expenses of transportation, and for reimbursement or for per diem in lieu of reimbursement for other expenses incident to his duties as such member:

(1) For transportation, the member is entitled either to the use of state transportation requests, or to be reimbursed for expenses of transportation to the same extent, in the same manner, and under the same conditions as provided for state officials and employees by the provisions of secs. 110-170 of this chapter.

(2) For reimbursement for other expenses, the member is entitled to per diem at the rate of \$35 a day for each day or portion of a day spent in actual meeting or on an authorized official business incident to his duties as such member.

Sec. 6. This Act takes effect July 1, 1967.

Original sponsors: Fritz, Beirne and Bradner. Offered 3/2/67. Referred: Finance. In the House by the Health, Welfare and Education Committee. CS for House Bill No. 73, in the Legislature of the State of Alaska, Fifth Legislature, First Session.

#### A BILL

For an Act entitled: An Act relating to the disease Phenylketonuria; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

Section 1. AS 18.15.200 is repealed and re-enacted to read:

Sec. 18.15.200. SCREENING INFANTS FOR PHENYLKETONURIA.

(a) A physician who attends a newborn child shall cause this child to be tested for phenylketonuria (PKU). If the mother is delivered in the absence of a physician, the nurse who first visits the child shall cause this test to be performed.

(b) The Department of Health and Welfare shall prescribe regulations regarding the method used and the time or times of testing as accepted medical practice indicates.

(c) The necessary laboratory tests and the test materials, reporting forms and mailing cartons shall be provided by the department.

(d) All tests considered positive by the screening method shall be reported by the screening laboratory to the physician and to the department. The department shall provide services for the performance of a quantitative blood phenylalanine test or its equivalent for diagnostic purposes. A confirmed diagnosis of phenylketonuria shall be reported to the physician and to the department. The department shall provide services for treatment and clinical follow-up of any diagnosed case.

(e) When presumptive positive screening tests have been reported to the department, it shall provide, on request, either the true blood phenylalanine test or subsidize the performance of this test at an approved laboratory.

(f) A licensed physician or licensed nurse attending a newborn or infant who violates this section is guilty of a misdemeanor, and upon conviction is punishable by a fine of not more than \$500. However, a person attending a newborn or infant whose request for appropriate specimens from the newborn or infant is denied by the parent or guardian is not guilty of a misdemeanor. The fact that a child has not been subjected to the test because a request for appropriate specimens has been denied by the parents or guardian shall be reported to the department. The department shall administer and provide services for testing for other heritable diseases which lead to mental retardation and physical handicaps as screening programs accepted by current medical practice and as developed.

(g) In this section, "physician" means a doctor of medicine licensed to practice medicine in this state, or an officer in the regular medical service of the armed forces of the United States or the United States Public Health Service assigned to duty in this state.

Sec. 2. This Act takes effect July 1, 1967.



Introduced 3/28/67. Referred: Health, Welfare and Education. In the House by the Judiciary Committee. House Bill No. 324, in the Legislature of the State of Alaska, Fifth Legislature, First Session.

A BILL

For an Act entitled: "An Act relating to immunization in schools."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

Section 1. AS 14.30.065 is amended to read:

Sec. 14.30.065. SUPERVISION. The program of physical examinations and immunizations (VACCINATIONS) prescribed by secs. 65-125 of this chapter shall be under the general supervision and in accordance with regulations of the Department of Health and Welfare.

Sec. 2. AS 14.30.125 is amended to read:

Sec. 14.30.125. IMMUNIZATION (VACCINATION). If in the judgment of the commissioner of health and welfare it is necessary for the welfare of the children or the general public in an area, the governing body of the school district shall require the children attending school in that area to be immunized (VACCINATED) against the diseases the commissioner of health and welfare may specify.

Original sponsor: Rules Committee by request of the Governor. Offered 3/6/57. Referred: Health, Welfare and Education. In the Senate by the Judiciary Committee. HCS for Senate Bill No. 89, in the Legislature of the State of Alaska, Fifth Legislature, First Session.

A BILL

For an Act entitled: "An Act relating to civil liability for rendering emergency aid, and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

Section 1. AS 09.65 is amended by adding a new section to read:

Sec. 09.65.090. CIVIL LIABILITY FOR EMERGENCY AID. (a) Anyone who, without expecting compensation, renders care to an injured or sick person who appears to be in immediate need of aid is not liable for civil damages as a result of any act or omission in rendering emergency care or as a result of any act or failure to act to provide or arrange for further medical treatment or care for the injured person.

(b) This section shall not preclude liability for civil damages as a result of gross negligence or intentional misconduct. Gross negligence means reckless, wilful, or wanton misconduct.

Sec. 2. This Act takes effect on the day after its passage and approval or on the day it becomes law without approval.

Original sponsor: Hagglund. Offered 3/10/67. Referred: Rules. In the Senate by the Judiciary Committee. CS for Senate Bill No. 142, in the Legislature of the State of Alaska, Fifth Legislature, First Session.

A BILL

For an Act entitled: "An Act relating to medical malpractice actions."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

Section 1. AS 09.65 is amended by adding new sections to read:

ARTICLE 6. MALPRACTICE ACTIONS.

Sec. 09.55.530. DECLARATION OF PURPOSE. The legislature considers that there is a need in Alaska to codify the law with regard to medical liability in order to establish that the law in Alaska in this regard is the same as elsewhere.

Sec. 09.55.540. BURDEN OF PROOF. (a) In a malpractice action based on the negligence of a physician licensed under AS 08.64, or a dentist licensed under AS 08.36, the plaintiff shall have the burden of proving

(1) the degree of knowledge or skill possessed or the degree of care ordinarily exercised by physicians or dentists practicing the same specialty in similar communities to that in which the defendant practices;

(2) that the defendant either lacked this degree of knowledge or skill or failed to exercise this degree of care; and

(3) that as a proximate result of this lack of knowledge or skill or the failure to exercise this degree of care the plaintiff suffered injuries that would not otherwise have been incurred.

(b) In malpractice actions there shall be no presumption of negligence on the part of the defendant.

Sec. 09.55.550. JURY INSTRUCTIONS. In medical malpractice actions the jury shall be instructed that the plaintiff has the burden of proving, by a preponderance of the evidence, the negligence of the physician. The jury shall be further instructed that injury alone does not raise a presumption of the physician's negligence.

Introduced 2/17/67. Referred: Health, Welfare and Education, Judiciary and Finance. In the House by the Rules Committee by request. House Bill No. 201, in the Legislature of the State of Alaska, Fifth Legislature, First Session.

A BILL

For an Act entitled: "An Act requiring licensing of agencies providing child placement and counseling services."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

Section 1. AS 47.36.030 is amended to read:

Sec. 47.36.030. AUTHORITY TO ISSUE REGULATIONS. The department may adopt regulations and standards consistent with other requirements of law. This authority does not deny a religious group from establishing and operating an institution solely because of the prior installation or operation of another religious group in the same area. The authority to adopt regulations and standards shall be exercised to insure compliance with the intents and purpose of secs. 10-100 (80) of this chapter. The department may inspect and examine an institution, home or place, or the performance of a service.

Sec. 2. AS 47.36.070 is amended to read:

Sec. 47.36.070. VIOLATIONS. A person who violates a provision of secs. 10-100 (80) of this chapter or a rule or regulation adopted under secs. 10-100 (80) of this chapter is guilty of a misdemeanor, and upon conviction is punishable by a fine of not more than \$200.

Sec. 3. AS 47.35.080 is amended to read:

Sec. 47.35.080. DEFINITIONS. In secs. 10-100 (80) of this chapter

(1) "boarding home or foster home" means an establishment providing regular care for less than six children not related by blood or marriage to the foster parents;

(2) "department" means the Department of Health and Welfare;

(3) "institution" means an establishment providing regular care and services for six or more children not related by blood or marriage to the owner or operator;

(4) "nursery" means an establishment providing care and services for any part of the 24 hour day for a child not related by blood or marriage to the owner or operator.

Sec. 4. AS 47.35 is amended by adding a new section to read:

ARTICLE 3. AGENCIES FOR PLACEMENT AND COUNSELING

Sec. 47.35.100. LICENSE REQUIRED. (a) Without a license issued by the department in accordance with its regulations no person may operate an agency providing any of the following services:

(1) the placement of children for foster home care;

(2) the placement of children for adoption; or

(3) individual and family counseling.

(b) The license shall remain in effect until revoked for cause. The department shall give written notice of revocation at least 90 days before the effective date of the revocation.

(c) In this section "agency" does not include an individual who occasionally provides the services set out in (a) of this section.

# TRAINING PROGRAMS FOR PHYSICIANS AND DENTISTS AT ALASKA NATIVE MEDICAL CENTER, ANCHORAGE

Formal graduate medical education has come to Alaska. During the past several years the Alaska Native Medical Center has developed several training programs for P. H. S. physicians which have been approved by the American Medical Association and American Dental Association. Except for the dental program, the residencies are an affiliation with hospitals in the "lower forty-eight".

The following programs are currently in effect:

GENERAL SURGERY - One year, affiliation with Staten Island PHS Hospital.

THORACIC SURGERY - Three months, affiliation with Seattle PHS Hospital.

DENTAL INTERNSHIP - One year, complete program at Anchorage.

The dental internship is in its first year of operation with both positions filled and final review by the American Dental Association anticipated this spring. Consideration is being given to one year affiliation residencies in pediatrics and orthopedics. Interest in these programs has been considerable.

M. Walter Johnson, M.D.  
Clinical Director

# LEGISLATIVE EVENTS

## My Legislative Experiences in 1967

By Michael F. Beirne, M.D.

Address given to the  
Anchorage Medical Society  
May 16, 1967

Mr. President, Distinguished Ladies and Gentlemen at the head table, fellowmembers and friends.

Of course I was most pleased at the invitation given to me by our president to address the Society. As you know, I have learned over the years, the hard way, that Happiness is being loved by the Anchorage Medical Society.

The president first asked me to relate my experiences in Juneau; then later on he asked me to relate my experiences in the Legislature. I did not tell him, but he should be aware of the fact as I am sure that many of you are, that there is a substantial difference between the two. So what I plan to do this evening is to relate some of my experiences in this past legislature which I think will interest you, but as regards my experiences in Juneau I will only say that for me it was early to bed, early to rise, and to church every Sunday morning with all the rest of the boys.

It is most unfortunate that Dr. Fritz cannot be with us here this evening. In my opinion he was an excellent legislator. He is just as dedicated to representing his constituents in government as he is in his practice of medicine. He was efficient and hard working, and I might say that no one worked harder or did his homework better than Dr. Milo Fritz. You can take great pride in him, as I did. He

earned the respect of all his fellow legislators.

First let me say that the bulk of our time and energy in the legislature, that is for Dr. Fritz and myself, were spent on the malpractice legislation. Whether it will do the job or not, we don't know; but this is what our attorneys advised would help, the only thing that would help, and that it was the fair thing to do, and so we did it. We are proud of this legislation, and of our ability to see it through to law and I want to tell you more about it.

Let me also say that as freshman legislators we were all a bit dumb, quite a bit as a matter of fact, but then this couldn't be helped. I think we learned fast. At least we worked hard and long and diligently. I think this legislature was a serious, hard working, and sober group, perhaps the hardest working legislature since statehood. The Governor worked very hard, had many requests of the legislature, and I believe it was a most successful year.

The malpractice bill was a good one for us to break in on. First, as you know I did not introduce it immediately but kept waiting for the proper time depending the advice of several other parties. Finally I decided that there was no time like the present so I introduced it in about the third week of the leg-



islature. It was of course referred to the HEW Committee where Mrs. Banfield was chairman. It took a good selling job to convince this chairman that the bill had merit, especially since her husband is an attorney. The attorneys were inclined to look with a great deal of skepticism on this bill and gave every evidence that they intended to come to the hearings in Juneau prepared to torpedo this bill. Finally, after some delay, we were able to arrange to have public hearings held on the bill, and I must say that these hearings when held were excellent. The problem was thoroughly discussed, and believe it or not when it was all over a surprising unanimity of opinion resulted and our malpractice bills were given a green light. It is true that all three of us physicians worked hard in both the House and in the Senate to get these bills passed, but it is also very true that the two doctors from Anchorage who came to Juneau to testify at the public hearings, Dr. Charles St. John and Dr. Rod Wilson, very impressively stated our position. There is no question that their presence in Juneau and the testimony they gave was a major factor in the passage of this legislation.

This illustrates very nicely a point that should be made, and that is if you are interested in legislation, you should come to the Capitol and testify before the various committees to demonstrate that you are interested and that this legislation is important to you, the voter. You should seek out the individual legislators and discuss the problem with them. Physicians need to learn the necessity of lobbying. But I think we can learn it and I think we can do a good job of it. Unfortunately organized medicine should have been doing this many years ago.

To speed up the action on the malpractice bill, I received from our Medical Association Counsel. Attorney Jim Delaney, the latest version of the malpractice legislation which he favored and I passed it on to Dr. Paul



*Michael Beirne, M.D.*

Haggland who introduced it into the Senate. And it was this bill that finally passed, being a better bill than the one I had previously introduced. Success on our bills was due to the cooperative efforts of many parties and I should like to mention specifically House Majority Leader Ted Stevens as being a major help in the House and Senate Majority Leader Brad Phillips for his efforts in helping the physicians. The bill became law and as soon as copies are available from the printing department each physician will receive a copy of this new law.

The next move as far as professional liability insurance is concerned, I believe, is for the State Medical Association to attempt to reduce rates and increase coverage, using this new legislation as evidence that conditions have improved in Alaska, and attempt

to put together a large group which would be able to obtain insurance at much cheaper rates. Those physicians who already enjoy satisfactory rates could remain independent, but those physicians who cannot obtain satisfactory insurance could join the group.

On another subject now, I introduced over twenty bills into the House myself and several of these passed and became law. One of these was the bill dealing with adoption agencies which Fritz and I introduced together. Agencies may now be licensed to handle adoptions, a step in the right direction. Previously these adoptions had been handled by the State, or through attorneys only. Another bill which became law dealt with the Comprehensive Health Advisory Council, and certainly this Council is most important to members of the health professions. Eventually this is going to be an Advisory Board of Health when it gets fully developed, and it will become a very powerful influence in the lives of all practitioners in Alaska. This matter should be a topic for discussion at one of our regular meetings as a separate subject, and it would be helpful to have the Commissioner of Health present.

I also introduced three separate bills on alcohol. One of these passed and became law, and this bill changed the present law which failed to permit the arrest of a drunken driver on private property, for example a person drunk in a shopping center parking lot could not be arrested for drunk driving since he was on private property, not publicly owned property. The police officer's association worked with me on this bill, and the bill passed without any opposition to speak of, receiving solid support through both houses, and became law.

Another alcohol bill I introduced set the chemical standards for what is drunk driving; it also established the implied consent law which simply means that a person receiving a drivers license in Alaska will agree to take a chemical test for alcohol if requested to do

so by the police; if he refuses to take the test he must give up his driver's license. Several states have this type of law now, and again no major opposition was encountered, but we ran out of time before this bill could clear the Senate. I think it will pass next year early in the session.

Another bill I introduced was to change the makeup of the State Board of Medical Examiners. Members of the present Board must be appointed from the various judicial districts, and there never has been a physician in private practice in the Second Judicial District (Nome and Kotzebue area), or one there for any great length of time; therefore there is always one seat vacant on the Board. My bill would eliminate the need for appointing people from the judicial districts, and all members would be appointed at large. Juneau is entitled to two seats on the Board under the present law. A number of physicians objected to this bill however, but I doubt if they understood its purposes. Consequently I did not waste any time with this bill but moved on to more important things. Dr. Hal Bartko moved to Nome and we appointed him to the Board. It might be added at this point that the Board of Medical Examiners has not had a meeting in ten years, according to the records, so I don't think that membership on the Board carries with it much responsibility.

Another bill I introduced and which finally became law, was also opposed by some physicians as well as the Anchorage Medical Society, but again I think it was because it was a misunderstood program. This bill relieved the State of the necessity of performing premarital serological tests for syphilis for free. Under the new law, the Department of Health can determine in which areas of the State adequate private laboratory services exist, and then discontinue the free service. This is a step in the right direction if we doctors want to get the government out of medicine.

Another important bill which I introduced,



and which will undoubtedly gain a great deal of attention in 1968 from the medical group, is the clinical laboratory licensing act. This important bill requires that every clinical laboratory in the State be inspected and licensed annually. It also requires that laboratory technologists be licensed. Approximately one-half of all states have licensing acts at the present time. Much Federal pressure has been created to force licensure of clinical labs. Medicare legislation requires state licensure of labs, or at least the written approval following inspection. California has had a licensing act for over twenty years, and today is considered the leader in this area. The Alaska State Medical Association passed a resolution in 1965 endorsing licensure for clinical laboratories. It is very interesting that licensure is required of many different groups, including the barbers, the hairdressers, real estate salesman, etc. but licensure is not required of the clinical laboratory technologists. This is an important piece of legislation to many physicians and consequently I think the Medical Society should ask a committee to begin study in depth on this bill now, not at the last minute.

Now for a few other observations. Our Commissioner of Health, Dr. John Chapman, is in my opinion a sincere and hard working fellow, and most ambitious for our state. I think he is doing a good job, but only time will tell whether he can do the job that needs to be done. I think he can, that is my personal estimate. But I also believe we must cooperate with him and help him where we can. The job is a tremendous one, very complex, involves Federal and State participation in many, many programs, covers a tremendous area of human endeavor, and perhaps you don't even realize it yourself but the Department of Health even includes the jails.

Nobody lobbies for jails. Actually very little lobbying is done for health. Two ladies did a little lobbying for PARCA and ACCA,

but in general no one else lobbied for health at all. Compare this if you will to education which gets about 40% of the State budget, lobbies like crazy, has paid lobbyists there every day in the legislative halls, and the education group even works directly in the election of Senators and Representatives. Education may now be overdoing the job a bit in some areas, that is getting too much for education at the expense of other needy areas in the State. But you never see mothers marching for jails, or for welfare, or for sewers or clean water. Previous legislatures rarely had anyone from the Health Department over to testify on bills. The legislature, as all of us humans are inclined to do, frequently yields to the greatest pressure, and since there has been very little pressure in the health department, the health department is frequently ignored.

In the field of health the chiropractors and the dentists are perhaps as active politically and as aggressive as any group in any field. Within 24 hours after I introduced a bill on physiotherapists requiring licensure at their request, the chiropractors were sending telegrams, telephone calls, letters, etc., even a lobbyist who stayed ten days. The dentists had their annual meeting in Juneau during the legislature, and although to the best of my knowledge they have never had a malpractice action, a number of them insisted that dentists be added to our physicians malpractice bill, and also stated that unless the dentists were added they would actively oppose the bill. This infuriated certain physicians and caused some chilling of the usual good relationships that exist between physicians and dentists.

On another subject now, I would like to briefly discuss with you the "Boards". These are of two types, the business and professional Examining Boards, and those Boards and Councils which are advisory to the Governor and the Legislature.

The Examining Boards, such as the Board of Examiners, etc., were originally designed to screen, test, and qualify applicants to various businesses and professions. However, without exception, all the Examining Boards today have assumed the additional function of controlling the absolute numbers of new men admitted to the various businesses and professions in the state through the mechanism of raising up standards very high, ostensibly to protect the public, but in actuality limiting the numbers of applicants passed. To the best of my knowledge this is not true in medicine, but simply because we need doctors so badly that anyone with reasonable qualifications is admitted rapidly. You can practice medicine in this state on the same day you come here provided your credentials meet the scrutiny satisfactorily of the examiner.

But in the other professions the number of new men is carefully controlled. I think that law and dentistry are the worst offenders. This is reminiscent of the middle-aged guilds. Routinely law and dentistry fail 40 to 50 percent of the applicants. Personally I don't see how it is possible for a man to pass the exam given in California, or Pennsylvania, or Nebraska, etc., in either law or dentistry, but not be able to pass the Alaska exam. There must be something very special about the Alaska exam that causes so many applicants to flunk it.

Frankly, in my opinion, it is unreasonable to expect the Boards to be totally objective in examining applicants when each new person passed is a future competitor. The Boards are made up of human beings and it is predictable how they will think and act. I think the records demonstrate very clearly how the Boards will act, and they do act to limit competition severely. I have introduced legislation which will require that examinations for licensure in medicine, dentistry, or law, be given by a third party, such as a university and the only grade rendered is "safe or un-

safe to the public". The public does not require that every practitioner of the art be brilliant or have an I. Q. of 150. Ten other Representatives co-sponsored these bills with me. I should like to point out that certified public accountants and nurses both use the national examining system, where all exams are given and graded by a national office and are not subject to local prejudices, influences and politics. In my opinion this is the road to go.

The second type of Board is the Advisory Board or council, commission, etc. There are approximately 200 of them. This is a fantastic number and each one of them has anywhere from five to fifty members, all appointed by the Governor and many of them subject to approval by the Legislature. Medicine has its share also, including the Comprehensive Advisory Council, Alcoholism Council, Governor's Committee on Mental Health, on mental retardation, on rehabilitation, etc., etc. We have Fish and Game Boards, Commission on the Rights of Women, commission on the arts, a council on this and a council on that. You name it and we have it. Most of these members serve also at the pleasure of the Governor. Well the legislature spent more time than I care to remember appointing people to these Boards and Commissions. Many of these Boards or Commissions never meet or only rarely meet. It seems important to some people to be on these various Boards and Commissions even though they may never attend a meeting. Some of the legislators are very much concerned when someone from their district is not appointed to a board. I am afraid we legislators spend more time arguing about appointments to the various Boards than all these Boards and Commissions will spend during the year in actual meetings. This is not to say that some of the Boards or Councils are not hard working, or that they are not im-



portant because they are. We couldn't operate without them.

As regards the appointment of the Commissioner of Health, this was confirmed by the legislature on the fifty-fourth day in joint session by a 41 to 18 vote. The Democrats of course objected to his appointment, and the final vote was pretty much a party line vote to be sure. The Democrats, the opposition party, believed it to be their duty to oppose many of the Governor's appointments.

Another point I'd like to make is that there is always a great tendency to oversimplify any problem. We all do this in our own daily personal lives as well as in our businesses, and its done in political life also. Really, most problems are quite complex. We are all impatient and tend to think along these lines. Our own problems are very complex, but the other person's problems are ostensibly quite simple. I saw a lot of this in the legislature, that is, my bill is important but yours is not important. Let me tell you that its just like major surgery versus minor surgery and you know that it is major surgery if it is performed on you, but minor surgery if it is performed on someone else.

Well let me tell you this, that I learned a lot in the legislature, am a much better citizen today from my experiences, and I worked real hard. I did a great deal of homework. When the session was over I was exhausted. I think that a lot is expected of a doctor in the legislature. People tend to expect just a little bit more from the doctor, and in view of the fact that we physicians have been very extensively educated, I think the public has a right to expect more than average from us. During the legislature I was called on occasionally to give medical attention to my colleagues. Most of them were just strained, nervous, tired out, the same as I was. The work was hard, the hours were long, and frequently the pressure was extreme. A legislator will ask himself fre-

quently why he exposed himself to rigors of this pursuit, and well he might ask himself this question. I like to think that we doctors set a pretty good example in the legislature, and I believe we did.

Frankly it was a great experience, and also a very expensive one financially. At this time I should like to acknowledge my two partners, Dr. Fred Strauss, and Dr. Carl Beck, for their generous and thoughtful consideration in permitting me to be gone from my practice for almost three months, in the service of the State, because without their cooperation I could not have done it. And I am very grateful to them.

If you will study the past legislatures, you will note that the turnover of legislators is very rapid. After a man spends two to four years in the legislature, he generally has had the course, and he has to get home to his business and his family. I can tell you this that living three months in the Baranof Hotel can be real painful too. Three months away from your office creates its own little problems. And those long airplane rides on those ancient Constellations between Anchorage and Juneau has a way of affecting you, not to mention those instrument approaches into Juneau through the rain and the fog, down through those narrow mountain passes. That gets to you after awhile too. But it was a great education and a great experience, and I am glad I did it.

Now as far as the future is concerned, I don't know as yet. There are too many imponderables. I am convinced that doctors better get in and better stay in politics if we are going to have a voice in what's going on in government. There are others of you who are very interested in government and politics, and certainly very capable of serving in the legislature, certainly every bit as capable as I am, and for those of you who are interested, I urge you to seriously consider seeking public office in 1968 or later years.

# THE LEGISLATURE WILL GET YOU IF YOU DON'T WATCH OUT!

By Milo H. Fritz, M.D.

The question most frequently asked me was, "what are you doing in the legislature?" During the seventy-four days in Juneau, where I served in the House of Representatives along with Mike Beirne, I often asked myself the same question. The reason is that I consider serving in the legislature a way of saying thank you for the opportunities and wonderful life that I have been able to lead as a citizen of Alaska.

## Previous Experience

The year before we became a state, I ran in the primaries for the Senate as a Republican. I placed very high if not highest, but then, owing to severe and protracted illness in the family, I did not re-file with the advent of Statehood. Therefore, I will never know whether or not I could have served. Then in 1962, because I felt much as I had described in the paragraphs above, I finished a poor fifth among those running as Republicans for the gubernatorial nomination. In spite of the severe drubbing I took, I made many political and social contacts among people that ordinarily I would have never met, and from whom I learned much about the art, science, frustrations, and triumphs of politics. Accordingly then, when several prominent Republicans asked if I would be interested in running for legislative office in 1966, I decided to run. I chose the House, rather than the Senate, the choice of many of those who encouraged me to run.

My campaigning was severely curtailed by the necessity of going to the east coast of the lower forty-eight, in order to look after the health and affairs of ancient members of the family. Therefore, my political activities consisted of sending out cards and brochures, and putting up a few signs around town attesting to my interests in becoming a member of the legislature. The most significant assistance that I received was \$200.00 from my good friend, Mr. John Spahn, of the Physician's Optical Company, guild optician, who has assisted the people of Alaska and me on itinerant clinics throughout the state. Mrs. Margee Fitzpatrick, wife of Dr. James Fitzpatrick, out of the goodness of her heart sent out twenty-five hundred handwritten cards, extolling my many virtues at what she considered to be a key time in the campaign, just before election. Since I placed eleventh or twelfth out of fourteen, I consider Mrs. Fitzpatrick's contribution crucial.

After the election was over and the absentee ballots had been counted, and I was sure that I would be seated, I began frantic efforts to catch up on medical commitments and get ready for take-off to Juneau.

## The Drive to Juneau

I rented an Air-Stream motor home in order to test out the feasibility of this as a place in which to live, not only during the ses-



sion of the legislature, but also for the clinics that I hold twice a year in Southeastern Alaska.

Mr. John Spahn helped me drive this bus over the Chilkat Pass on the 18th of January. It was just exactly like driving around in one's deepfreeze. The little furnace was never designed to heat this monstrous body over twenty-eight feet in length, and six feet high, and about six feet wide. Everything but the windshield in front of our faces, was coated with a half-inch of ice. We wore arctic underwear, parkas, and fleece-lined boots, and nevertheless were cold. The temperature inside the cockpit got down to 20 degrees below zero. The only warm place in the entire bus, besides the engine, was the refrigerator!

The second night out, the temperature got down to 38 degrees below zero. When we started up the engine, we could just barely turn the wheel in spite of power steering assist. Eventually we got over Chilkat Pass, white and forbidding, down to Haines where the temperature rose above freezing, and we felt positively tropical after the two days of sub-zero driving.

### Life in Juneau

In Juneau, I parked the bus in the section of Juneau near the new Federal Building. As some of you may recall, they had the highest winds, the greatest snowfall, and the lowest temperatures ever experienced in Juneau. The old bus bucked and kicked and some of the high winds made me afraid it might actually be blown over.

The bus was about three-quarters mile from the Capitol. It was possible for me to get in about five miles of walking a day. This is a very important item when one had to spend most of his time on his backside either in committee meetings, in sessions of the House, or standing in front of the snacks and hors d'oeuvres at the receptions held by the various groups in the hospitable city of Ju-



*Milo H. Fritz, M.D.*

neau, during the time that the legislature is in session.

The people of Juneau made us welcome with placards, that allowed us to park where we could during the first few days until we could find permanent places for our vehicles. The banks offered us their facilities at no charge. We had a little coffee shop and frequent mailings to and from the Capitol building throughout the sessions, week-ends, and Sundays, and we had the help of as fine a battery of young men and women to help as Secretaries and Clerks, as anyone could ask.

The house of representatives has forty members, thirty-nine of whom are men. They ranged in age from twenty-two to the late sixties. Some were highly educated formally, some had vast experience. There were miners, trappers, guides, school teachers, two

physicians, store keepers—a cross section of the people who live in Alaska. There were two full blooded Eskimos, one man who is half-Eskimo and half-White, a lone lady who came from Juneau, and has been long prominent in civic and political affairs in Southeastern Alaska.

The Governor made available the Chiefs of all his departments to testify at the hearings of the committees and at special hearings.

I was given the work on the following committees: Health, Education and Welfare; Judiciary; and State Affairs. This meant at least an hour and sometimes two hours a day in each committee, plus hearings at night, and the necessity of answering letters and telephone calls. Besides, I did research on legislation with the help of the Legislative Affairs Council, and the various state agencies, commissions and individuals as matters came up for study and consideration.

My chief interest, of course, is the health problems of rural Alaska. I compressed twenty-seven years of experience into a twelve and one-half minute speech, which was enthusiastically received by my fellow legislators. However, what hurt was that the press stayed away in droves, and only one kind hearted lady who is the Alaska Representative of a national news service put a very short summary of my remarks on Page 4, of her particular paper.

The receptions that were held, particularly frequently during the beginning of this session, were sponsored by Chambers of Commerce, loggers, miners, fishermen, crab people, construction folks, labor unions, everybody who was interested in passing a particular piece of legislation or having it stopped at any cost.

Violent debates sometimes arose in the House. But no matter how angry one became on the floor, or how tricky and complicated the debate waxed and waned, when the session

closed for the day sometimes the bitterest opponents would be seen happily with their arms about one another's shoulders, or drinking coffee in the coffee room.

I introduced bills to require plastic lenses of a certain thickness and glass lenses to be case-hardened before they could be sold in Alaska. This was bottled up in the Senate because of the interest of a certain group of local people in Fairbanks, who had a large stock of substandard sunglasses for sale. I was also, of course, vitally interested in the problem of our malpractice situation in Alaska. Mike Beirne and I got this corrective legislation thing through the House, the Senate, and the hearings. It was finally signed into law by the Governor.

I was also interested in exposing the substandard sections of the Alaska Native Health Service. Legislator after legislator from the bush area came to me with letters from his constituents complaining about the poor quality of health and dental services in the area. Nevertheless, I am driven to the conclusion that they are not really interested in these things, because when the time came to stand up and add to the testimony I gave, large gobs of silence resulted. It looked as though I was slightly touched on the subject of rural health, and so very little was accomplished.

On the negative side, but still important, many a bill of a medical or public health nature that would have been most unfortunate, like the PKU bill of last year, was never introduced when we physicians pointed out that they were impractical, unscientific, served a special interest or were against public policy.

At the very last minute, I introduced a bill making it illegal for anybody but Medical Doctors to use the word "doctor" in advertising their skill to the public on signs or stationery as long as they dealt with the healing arts. In other words, anybody who is a Chiropractor, and Optometrist, an Osteopath, or anything else, must put his name down as John



Smith, followed by whatever he is, so that the public can choose among us as to which he wants to take care of the health of his family or himself. The only exceptions would be the Veterinarians who are not interested in treating human ills, and the Dentists who wish to stick solely to matters pertaining to Dentition. No doubt there are going to be many hearings and the Chiropractors and the Osteopaths and others are going to explain what marvelous training they have, and how in every way they are superior to all other practitioners of the healing arts, especially the bonafide Medical Doctors. Just as a contents of a can of dog food must be accurate and advertising must disclose the true facts concerning the product, I say that the public should know what kind of a "doctor" it is visiting. This bill in no way impugns anybody's training or ability, but merely makes it possible for the public to distinguish between the various practitioners that they may be called upon to visit and make an informed and intelligent choice. I will need the help of you all if this is to pass.

I am greatly interested in having ferry service inaugurated on the Yukon, and particularly interested in having a canal built between the lower Yukon and the lower Kuskokwim rivers so that effectively the mouth of the Kuskokwim will serve as the mouth of the Yukon. This will make it possible for ocean going vessels to unload directly to river barges at Bethel—cutting down the cost of freight to and from the outside an impressive amount. Also, it would make it possible for the people along these two great rivers, who are the poorest in the nation, to enjoy a little of the money brought into the state through industry and by tourists.

Between sessions I will be busy interviewing groups of citizens and individual people who wish to have things done differently, not done at all, or have a law amended, repealed, modified, or substituted for. I will continue

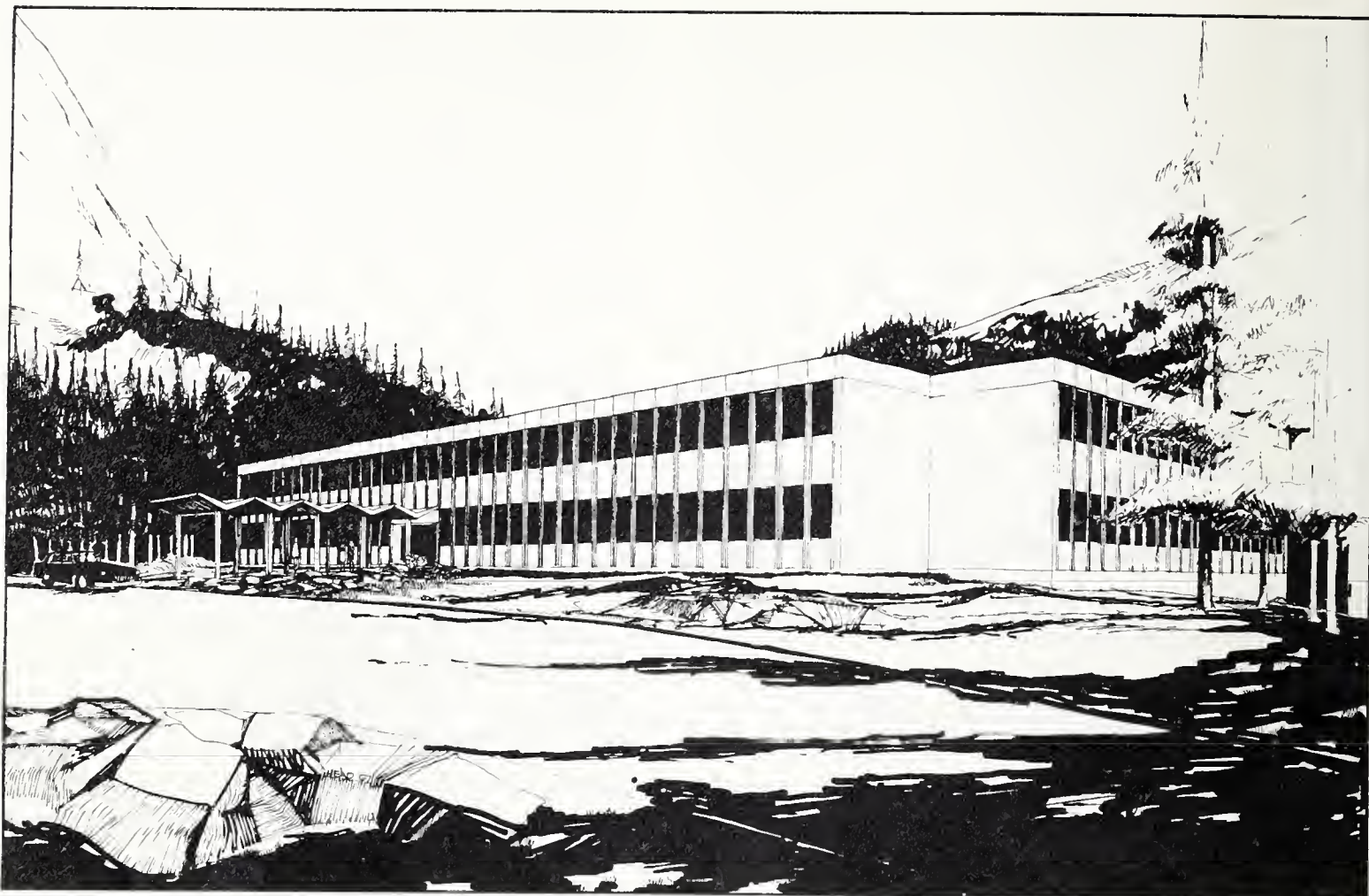
working on the Yukon Ferry, and the Yukon-Kuskokwim Canal, and of course, will continue to hammer away at the Alaska Native Health Service, so that it can be put under the control of the State, where the quality and kinds of medical and dental care will be under local control, instead of the remote and inefficient control of people in Washington, D.C.

I am also interested in having legislation enacted to train village aids in dentistry and medicine, much as they are in the Cook Island Federation, where the activities of these people are governed by the medical men and the dentists of the state.

They must have restricted licenses, pay, and certain clear cut responsibilities. What this will do for rural Alaska can best be judged by the good it has done in the Cook Island Federation and by the work of the late Jimmy Otiyuhuk, who was a dental assistant in the village of Gambell, in St. Lawrence Island, where the teeth of the people of that village were an example for the rest of the native villages to envy.

All these things constitute, no doubt, an ambitious program. Doubtless, I will be unable, even in the next session, to get them through. Even though it seems frustrating to work a bill through committees of one House, only to have it knocked down in the committees or the floor action of the other House, nevertheless this sort of legislation has resulted in the establishment of the greatest country in the history of the world. Sure there are more efficient ways. But who wants another Hitler?

As to running again, I feel now I cannot afford it. However, if the Republican party, and above all those who voted for me, feel that I have done a good job and let me know clearly before the election next year that they think I was an effective, sincere, and honest legislator, I think I could be persuaded to try serving another session in the House.



GREATER JUNEAU BOROUGH HOSPITAL

*Tentative Sketch*

OLSEN & SANDS • ARCHITECTS • A.I.A.

## CAPITAL CITY'S HOSPITAL, OLD TO NEW

By Robert G. Ogden

Completion of the new Greater Juneau Borough Hospital in 1970 will mark the end of 80 years of community service by the Sisters of St. Ann's Hospital. The decision to close existing facilities was first announced in October, 1965, when the Sisters found it unsafe to continue in the old building and impossible to obtain a new one.

In September of 1964 the Sisters realized the 1913 and 1914 sections of St. Ann's

Hospital must be replaced because of inadequate service areas, obsolete floor planning, and substandard fire and safety conditions. The firm of Olsen and Sands contracted to provide a master plan for modernization and expansion of the hospital. At this time application was made to the U. S. Public Health Service Hill-Harris Regional Office about the possibility of their participation. Hill-Harris, a federal program under USPHS,



provides on a matching basis, funds for the construction, modernization and expansion of approved hospitals.

In May 1965, the subcontracted architectural firm of Stone, Marracini and Patterson presented their preliminary plan for the Sisters' approval. Simultaneously, the Hill-Harris office advised that federal funds would not be available because the newer portions of St. Ann's Hospital did not meet the regulations of the Hill-Harris Act. Furthermore, in August of 1965, Hill-Harris informed the Sisters that their present site was unsuitable. This was disheartening news to the Sisters because federal funds were essential in order to proceed with the proposed renovation. Dismayed, but undaunted, the Sisters began a search for a new site. Again they ran into obstacles. There was only one site available and the cost of the site was so great that with the cost of hospital construction, it would be impossible to finance the project. These obstacles brought about the October 1965 announcement that hospital services would have to be provided by others.

Upon receiving the announcement of the Sisters' intentions of leaving Juneau, Mayor Larry Parker appointed a committee of residents to study hospital problems and asked that they submit their recommendations to the city council and administration. This committee, in its first meeting, agreed that hospitalization should be handled on an area wide basis and that a new Borough hospital was needed.

The chairman of the Greater Juneau Borough, Mr. Claude Milsap, Jr., immediately appointed a Greater Juneau Borough Hospital Planning Committee. This committee of borough residents was instructed to study and recommend to the borough, the size of the hospital needed, facilities needed within the hospital and the type of administration most favorable. This committee was composed of residents who had prior experience in hos-

pital planning, employees of St. Ann's Hospital in the technical and professional fields, local physicians, engineers, and businessmen. The Hospital Planning Committee met with their State Hospital Facilities Office, the physician and personnel of the local mental health outpatient clinic, the medical society, the architectural firm, the Borough Planning Commission, the Greater Juneau Borough Assembly, etc. After consideration of the facts accumulated, the committee recommended that the new hospital contain 60 general hospital beds, 20 long term care beds, a mental health out-patient clinic, space for the USPHS Alaska Native Division out-patient facility and examining rooms for various specialists who arrive in Juneau to conduct clinics. The recommendations of the hospital planning committee were accepted in August of 1966.

Also in August, the Borough Assembly issued an ordinance asking the voters to approve a 1.8 million dollar bond issue for the borough's portion of construction costs for a 4.9 million dollar hospital. In early October of 1966 the 1.8 million dollar bond issue was passed.

With the approval of the bond issue, the Borough Administration submitted to Hill-Harris and the State Hospitals Facilities Office, the first portion of the required application. After researching 18 possible locations, the Borough Assembly approved, in January 1967, what is known as the Salmon Creek Site as the location for the new hospital. Salmon Creek is located three miles north of Juneau on the Glacier Highway.

With the site chosen, the financial obligation of the sponsor (Borough) fulfilled, and part 1 of the Hill-Harris and State applications submitted, the second and third parts of the necessary applications were completed and transmitted in February 1967. As planning progresses through the various stages, a new hospital will slowly evolve.

# MUKTUK MORSELS

CHICKEN: A letter from Dr. Aloys J. Daack, Chicken, Alaska, states that his general practice office is located "at the Biglowe Mine, in the Heart of the Forty Mile, on Taylor Highway at Mile 69" (look carefully between Tok and Dawson).

NOME (DIARY): On Friday January 13th I flew to Nome for a 4 day weekend of general practice. Before departing I was briefed on Roseola, Rubella and "runny ears". After some mechanical difficulties (a malrotation of the propeller) the plane finally arrived at Nome. I was soon put to work by Dr. Merritt Canfield, a retired San Diego cardiologist, who was pinch-hitting while the Hospital Board tried to line up a contract physician. Dr. Canfield had already put in four very strenuous weeks before my arrival. He replaced an internist, Dr. Richard Lang of Schenectady, N.Y. who volunteered for two weeks on departure of Dr. Carroll H. Long and Dr. Glenn D. Blaisdell late in November. Dr.'s Long and Blaisdell had been in Nome for four and five months respectively. They in turn had replaced Dr. Robert E. Fenstermacher who was in Nome for four years following closure of his mission hospital in the Congo (present address Walkerton Medical Clinic, Walkerton, Indiana). During Dr. Fenstermacher's stay in Nome he was supported by Dr. John A. Shadler who left in September 1964, by Dr. Canfield for a 3 month period and by Dr. Robert Lott who remained for 16 months before returning to Mississippi in May of 1966.

I might add that Dr. Robert Fraser, Director of the State Tuberculosis Control Program, kept his medical finger in the dike dur-

ing a long four day weekend between doctors in November, to the great gratitude of all Nomans.

The medical situation in Nome is unique in Alaska. The Maynard-McDougall Memorial Hospital is a Methodist Mission Hospital of about 25 beds. This hospital, which serves a large area of Northwest Alaska, runs a yearly deficit of about \$ 30,000, which is made up by the Women's Division of the Methodist Church, formerly known as "The Ladies' Aid Society". In the past some physicians have worked here on a volunteer basis, and some under contract. Until recently all major hospital decisions were made by the Mission Board in New York. I understand that the local trustees headed by Mr. Don Hoover, a Nome Banker, have been granted more autonomy following the recent rapid turnover of medical and paramedical staff.

The population of Nome is under 3,000 and over 80% Eskimo. Thus the major portion of the hospital outpatient and inpatient services are provided under contract with the U.S.P.H.S., which also supervises inpatient care somewhat by teletype. Nome has the only hospital north of Fairbanks treating non-native civilians for routine medical problems. This hospital also treats all Eskimos between the Kotzebue and Bethel Public Health Hospital service areas. I might add that a U. S. P. H. S. hospital is projected for the Unalakleet area, although the native population to be treated by this new facility centers on Nome.

In any case the annual hospital deficit is incurred largely in the contract care of relatively indigent U. S. P. H. S. beneficiaries. At this time there is no tax base to support a



hospital locally, although offshore gold dredging could conceivably alter this.

Of the many medical problems I saw during my several days in Nome, I can say little, except that I arrived during an epidemic of G. C., tonsillitis, strep throat, otitis media and what-not; all of which I discovered are manifestations of the "penicillin-deficiency syndrome". The one patient with pulmonary edema we had did very well.

No medical report on Nome should ignore the town water and sewage systems. For any appreciation of these systems, consideration of the climate and permafrost are essential. Although some homes and hotels have piped in water from a nearby river, many homes get their water through the long winter by melting ice on the stove. Much of the town's sewage system is still "honeybucket". The contents of this chemical toilet contraption are collected by the local specialist and dumped "in a remote area". Those who can afford this "service" are presumably not alarmed by the occasional sudden disappearance of their hopefully unoccupied toilet out through the house wall. It is alleged that those who cannot afford this service are not greatly discommoded, as there is no problem until the late spring thaw in any case.

After my tour in Nome had officially ended, another 36 hours went by while a modern turbo-prop airplane waited out an old fashioned blizzard, again emphasizing the medical isolation of this community and its physician.

After Dr. Canfield's departure consecutive coverage was provided by two resident physicians from the State University of Iowa Hospitals, pending the arrival of Dr. Harold Bartko who moved to Nome from Anchorage.

FAIRBANKS: We understand that St. Joseph's Hospital in Fairbanks has obtained a stay of condemnation of one wing of the hospital by installation of a sprinkler system. With the centennial tourist season ahead and

an already crowded facility, the Fairbanks Medical Society is pushing for additional space, possibly in the form of an adjoining inflatable building. Otherwise they expect hospital corridors full of beds for the summer. Planning for a new community hospital almost ended when the voters rejected a proposed hospital bond issue last year. However a Borough Advisory Committee was recently organized to reassess this problem. Dr. Joseph Ribar has been appointed to this committee.

Dr. Henry Green, Fairbanks only anesthesiologist, is moving to Madera, California. So far no physician replacement is in sight, but St. Joseph's Hospital plans to hire a second nurse anesthetist as soon as possible.

Lt. Colonel Edwin Lindig Jr., former commanding officer at Bassett Army Hospital, presently Chief Surgeon, U. S. Army Alaska, expects to retire and join the Fairbanks Clinic in Orthopedics this September. Lt. Colonel Lindig is Board Certified in Orthopedics.

Major William F. Kinn, Chief of the Department of Surgery and Director of the Ophthalmology Service at Bassett Army Hospital plans to enter the private practice of ophthalmology in Fairbanks in September. He is Board Certified in Ophthalmology.

Dr. F. L. Gobble, formerly of Fairbanks, is now an Assistant Professor of Obstetrics and Gynecology at Bowman-Gray Medical School.

ANCHORAGE: The Presbyterian Hospital of Anchorage has been sold to Pioneer Associates, a Seattle-based hospital management and supply group, and renamed the Anchorage Community Hospital. Mr. Vernon Perry had resigned his post as administrator of the Anchorage Community Hospital to become resident director of the Pioneers Home in Sitka, as well as director of the Pioneers Home in Fairbanks.

Dr. Karl Bowman, former director of the Division of Mental Health and Superintendent of The Alaska Psychiatric Institute has retired, for the third time, and returned to California. Dr. Bowman is nationally known, having been active in psychiatry for fifty years. Dr. John P. Rollins, Chief of Psychiatric Services at A.P.I. is acting superintendent pending the arrival of Dr. Carl D. Koutsky of Minnesota who is expected in September. We understand that Dr. Koutsky turned down a full professorship at the University of Minnesota Medical School, where he has been teaching psychiatry, to take charge of A.P.I..

Dr. Richard A. Peterson, from Illinois, will join the Anchorage Pediatric Group in September. He is Board Certified in Pediatrics.

Dr. David Dietz will join the Doctors Clinic in July on completion of his surgical training at Stanford.

Dr. William Mills will return to Anchorage this summer after a year in Vietnam. He plans to take a one year appointment as Visiting Professor of Orthopedics at Vanderbilt Medical School in Nashville before reopening his private practice in Anchorage.

Dr. Frank Nicholas has opened a private office in general practice at the College Medical Center.

Dr. Carl Beck passed his clinical and anatomical pathology boards last November.

Dr. George Wichman survived the ordeals of winter mountaineering on the slopes of Mt. McKinley and can still count to 20 with his shoes off. One climber fell to his death on this first successful winter climb of Mt. McKinley.

Dr. Robert Wilkins was recently elected president pro-tempore of the Greater Anchorage Borough Health Council.

A bulletin from the AMA informs us that Dr. Alan Homy will be in Vietnam for 60 days

under the AMA Volunteer Physician Program from May 8 to July 6 1967.

Dr. Paul Scholtens is leaving the Doctors Clinic and Anchorage Community Hospital to practice radiology "outside". So far no replacement has been found.

Dr. Robert Townley left the Anchorage Clinic and after a short period of private practice left Alaska "to take a barge trip down the Mississippi".

Dr. Fred Strauss finally got his first son after four daughters.

Dr. Howard Romig had his 13th child, 7th daughter.

Drs. Marianne and Arndt von Hippel had their 3rd son, fourth child.

Eagle River will finally get a physician when Dr. Thomas F. Green of Pittsburg opens his office in general practice this summer. Dr. Green has been with the Public Health Service for two years in Anchorage.

SEWARD: Dr. E. A. Watson from Nebraska will open an office in general surgery in association with Dr. Ernest W. Gentles.

KENAI: Dr. Robert Struthers left Kenai and returned to Oregon after one year in private practice.

Dr. O. H. Armstrong has opened an office in general practice in Kenai, but we understand that still another man is needed there. At present Dr. Paul Isaak and Dr. Elmer Gaede are spread rather thin between Kenai, Seldovia and Soldotna. This year again they are supplementing their medical staff with externs and residents on rotation or vacation from the State University of Iowa. From all reports this has turned out to be excellent clinical experience for the Iowa doctors as well as a great help on the Peninsula. Certainly it presents good possibilities for physician recruitment in an attractive and booming area.

Also booming is Dr. Charles F. St. John's



new 20 unit motel with 24 hour restaurant and cocktail lounge, the "Port Inn" in Kenai, just across the street from the new chemical plant.

KODIAK: Dr. John Eufemio is returning to New York after one year because of family health problems. Until another general surgeon is found Dr. Mildred McMurtry, a general practitioner from Cleveland and Dr. R. Holmes Johnson will have an empty office in their beautiful new clinic building with the "million dollar view".

JUNEAU: Dr. Robert Reynolds has resigned from the Juneau Clinic and gone "Outside". Dr. W. J. Chapman has announced termination of the state Crippled Children's Services contracts with the University of Washington Medical School. Dr. Chapman points out that competent orthopedic and ophthalmologic consultations are readily obtainable within the State.

SITKA: Sitka should be bursting at the seams by meeting time. A number of random room sharing arrangements have been made by hotel and motel keepers which may prove interesting. An excellent program has been prepared, so bring your fishing rods.

Dr. George Longenbaugh, a Board certified general surgeon who has been in charge of the Department of Surgery at Mt. Edgecombe for a number of years, will retire from the U.S.P.H.S. this summer and enter private practice in association with Dr. Philip H. Moore.

KETCHIKAN: From Ketchikan we hear that Mrs. Arthur (Sharon) Wilson has been appointed to the State Nursing Board. Dr. James Wilson has been appointed to the Alaska State Board of Medical Examiners to fill the vacancy created by the recent death of Dr. William Whitehead. This Board will meet in Sitka to elect a secretary-treasurer to handle

applications and correspondence. Until now this office has been appointed by the governor.

Dr. Hilbert Henrickson from Oregon, presently stationed at McCord Air Force Base in Washington, will enter general practice in association with Dr. James W. Mortensen in July.

The Heart Stroke and Cancer program is slowly progressing. So far the emphasis has been on data gathering. Through the efforts of Mr. Bob Ogden and the statistical group in Seattle we should have a series of maps and tables for our September issue of considerable interest. We hope to plot all medical facilities and physicians, provide present and projected population figures, and give some estimates of disease incidence and where treated; in a manner that should be helpful to both private physicians and health agencies. Incidentally the Alaska Medical Society has been promised a subsidy for this work by the regional advisory group, related to the proportion of Mr. Ogden's time required. So far two Alaskan proposals have been presented to the Heart Stroke and Cancer regional advisory group. These are now under evaluation. The first is an application for money for the purchase of a cobalt therapy unit to be housed next to Providence Hospital. A group affiliated with the American Cancer Society has been set up to raise necessary building funds. The other request is for financial assistance to a proposed area medical library facility now being organized at the Alaska Native Medical Center. This project was stimulated by the impending transfer of the Arctic Health Research Library facilities from Anchorage to Fairbanks.

Other topics under consideration include the several proposed or actual coronary care units around the state. In particular the problem of teaching the special coronary care nurses needed to adequately staff such a unit has been extensively discussed. There are

programs now available where such people can be educated. The necessity for continued education using audio-visual facilities is currently being investigated. The required teaching equipment and materials could be obtained either through the regional program, or by teaching grants from the Heart Association as has been done in Washington.

Other subsidized programs for the further education of necessary paramedical personnel apparently can be worked out when the need is demonstrated and a candidate for training is available. For example the training of combination laboratory and x-ray technicians for isolated areas, or supplementary cytologist training, have been discussed as definite possibilities. Also being discussed for the near future is telephone transmission of EKG's for emergency consultations from more remote areas. This should be possible soon in Alaska. It has been shown to be practical in other states and the equipment is not overly expensive.

The major and relatively untouched field of post-graduate medical education has received

due attention. Certainly there are many medical fields where the need for further education is not met by the deluge of journals, or even by occasional attendance at a medical meeting. In addition, some form of a reasonable break from practice on the idea of a sabbatical year might be welcomed by many overworked and isolated physicians and their families. A suggestion of apparent merit would permit financial self-assistance to the physician contemplating further education in his own field, in the form of a tax break, or preferably a tax credit. Certainly the use of one's own tax money should be less expensive for all than the bureaucratic recirculation, with multiple extractions, of the equivalent amount in the form of federal largesse. An increased demand on post-graduate education facilities should hopefully improve their quality, variety, and applicability.

Even should the whole Heart Stroke and Cancer program fizzle, it will have served as a stimulus to busy physicians to think in regional terms and plan beyond their next patient.

Erratum: In the March issue of Alaska Medicine, page 12, Mr. Parrish of Fairbanks was mentioned in connection with the Johnson-Tatum case. Mr. Savage has informed us that although Mr. Johnson originally consulted Mr. Parrish, he then was referred to several attorneys, that Mr. Johnson selected Mr. Savage to represent him, and that Mr. Parrish thereafter did not participate or have any financial interest in this case.





# CASE REGISTRY FOR HANDICAPPED CHILDREN

By **D. V. Reddy, M.D., M.P.H.\***  
and

**Jon M. Aase, M.D.\*\***

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Two recent events--the thalidomide tragedy and the nation-wide rubella outbreak of 1964-65--have focused attention upon "epidemics" of congenital abnormalities. In the hope of averting future episodes of this kind, surveillance systems have been set up in some areas to detect unusual increases in the occurrence of handicapping defects.<sup>1</sup> In other places, registries for the handicapped have existed for some time, and have provided valuable information about the prevalence of certain diseases, and the availability of services for those afflicted.<sup>2,3,4,5</sup>

These reporting systems function with varying degrees of success and most are heavily dependent upon compilation of data from hospital records and mandatory birth and death registrations. The limitations of these sources of information are obvious, and some major handicaps, including deafness, mental retardation, and cerebral palsy may never come to light in such a system.

Because of the restrictions imposed by the analysis of vital statistics alone, a more comprehensive, voluntary registry program was established in the Province of British Columbia in 1952 and has enjoyed great success.<sup>6</sup>

The Alaska State Department of Health and Welfare has used this proven system as a model in planning a state-wide Registry for Handicapped Children, and the generous advice and assistance of consultants from the British Columbia Registry has been invaluable in laying the groundwork for this program.

The working definition of a handicapped person for the purposes of the registry is "one who possesses a physical, mental, and/or emotional problem which is likely to be permanently disabling, to interfere with his education or to prevent full and open employment. This includes children with congenital malformation or familial conditions which may or may not be permanently disabling."

In Alaska at present, information concerning handicapped persons is scattered and fragmentary, and the magnitude of any particular problem is difficult or impossible to assess. Various agencies, professional people and organizations have expressed considerable interest in establishing a statewide case registry of handicapping conditions,

which could facilitate provision of care for the individuals involved.

The advantages and uses of the registry include the following:

1. Routine reporting will identify children who need care but might otherwise be missed. This early case finding will encourage referral of the individual to a physician for proper care. It will also provide a reminder service to insure that instituted care is adequately followed up and that children are not "lost" before all necessary rehabilitation procedures had been instituted.
2. The registry will identify more specifically the prevalence of various handicapping conditions in Alaska and indicate where attention should be directed. This will be of great value in establishing priorities and planning programs of special education, rehabilitation, and other services.
3. Registries in other jurisdictions have proved invaluable in research and are being used extensively for this purpose. It is anticipated that an Alaskan registry would function in this capacity also.
4. Through routine reportine, "epidemics" of congenital defects can be identified early so that etiological studies can be undertaken. Since most birth defects are rare, a relatively large number can occur before anyone becomes aware that a problem exists and investigation and remedial action can be instituted.
5. Families whose children are at greater than average risk of having handicapping defects can be identified so that children born to those families can be given special surveillance and thus reap the benefits of early diagnosis and treatment.

The development and maintenance of a

successful registry in Alaska will depend upon cooperation from many sources: private physicians, hospitals, public health nurses, voluntary health agencies, and others. The data supplied from these various sources must be collated and coded in the registry, and can then be made available to qualified and responsible organizations and agencies for the purposes mentioned above. An advisory committee will be established to insure the proper use of the information and the maintenance of its confidentiality.

A simple reporting card has been developed which becomes the basic history record for each case. Blank forms will be supplied to physicians and agencies as needed. When the completed forms are returned, the data will be transferred to IBM punch cards for statistical processing.

Registration is, of course, voluntary, but if the benefits mentioned earlier are to be achieved, the information obtained must be as complete as possible and from as many sources as are available. Some duplication of reports is unavoidable, but this can be handled easily within the registry mechanism. Furthermore, this will provide an internal check on the accuracy of the data and insure identification of all those who may be involved in the care of the individual.

Conditions are ideal for the establishment of a registry in Alaska at this time. The population base is reasonably small, health programs have not grown to an unwieldy size, and enthusiastic support for the program has been offered from many sources. Initially, the registry will be concerned only with children, but as the system develops and other needs become apparent, it can readily be extended to include handicapped adults as well.

One word of caution: despite the many advantages of the registry concept and the enthusiasm that has developed within the state, it would be unwise to expect too much too soon. Alaska's situation is in many ways



unique, and will demand unique solutions to problems as they arise. To be effective, a registry program cannot remain static, but must be capable of adapting to the changing needs and character of the population. With

such adaptability, together with the continued support and good will of those upon whom the registry depends, its eventual success is assured; the potential gain for the state of Alaska is immeasurable.

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# Classified Ad Section

To provide members with an opportunity to make known their needs for medical and paramedical personnel. Please address all correspondence regarding insertions to: Robert G. Ogden, 519 W. 8th Avenue, Anchorage, Alaska 99501.

ALASKA — LAND OF UNLIMITED OUTDOOR RECREATION needs Internist; immediate association with well established group in Southeastern Alaska. Substantial salary initially, partnership after one year. Stable economy with rapid growth and industrial expansion. No investment required. Reply to the Juneau Clinic, 188 South Franklin Street, Juneau, Alaska 99801.

SELDOVIA IN NEED of full or part time physician. Hospital available, living and office quarters furnished — guaranteed salary. Interested physicians please contact: Darlene Kashevarolf, City Clerk, Seldovia, Alaska.

EXPERIENCED MEDICAL TECHNOLOGIST — full time. Salary based on experience. Write Ruth Serfass, Fairbanks Medical & Surgical Clinic, Box 1330, Fairbanks, Alaska 99701.

ANCHORAGE MEDICAL & SURGICAL CLINIC announces openings for Internist, General Practitioner, and Orthopedic Surgeon. Would like young men under 40 with military obligations fulfilled. If interested, contact: Howard G. Romig, M.D., 718 K Street, Anchorage, Alaska 99501.

GENERAL SURGEON needed in Kodiak, Alaska. Independent practice if desired, with share of overhead and operational expenses in new clinic. Minimum guarantee \$18,000. Contact R. Holmes Johnson, M.D., Box 766, Kodiak, Alaska.

GENERAL PRACTITIONER WANTED — ASSOCIATE POSITION; this opening includes plans for a possible future partnership. New office with all facilities available. Contact Royce H. Morgan, M.D., 1844 West Northern Lights Boulevard, Anchorage, Alaska 99503.

OB-GYN ASSOCIATE opening available; preferable to be board certified, will consider board eligible. Reply to L. David Ekvall, M.D., 207 East Northern Lights Boulevard, Anchorage, Alaska 99503.

# AMA ARCHIVE-LIBRARY

*Occasionally in the deluge of releases and bulletins to which Alaska Medicine is heir, a noteworthy item is received. The following AMA release should be of interest to Alaskan physicians generally, relating as it does to current plans for Alaskan Library facilities and postgraduate medical education generally.*

A young intern, hoping to practice medicine in East Africa after receiving his license, wants to correspond with medical people already practicing there and needs names and addresses. He writes to the American Medical Association Archive-Library for assistance.

A doctor, well established in a practice he has maintained for twenty years, finally gets the opportunity to take his wife on their dream tour of Europe. They will be in Switzerland in July. He wonders if there will be any medical meetings he can attend in Switzerland during their visit. He writes to the Archive-Library for information.

A general practitioner has a patient, a 17-year-old girl, who is planning to attend a year of school in Guatemala. She is a potential surgery patient. He is concerned about the type and quality of medical service available in the region. He writes to the Archive-Library for help.

You could be any one of these AMA members who benefit from the services of the AMA Archive-Library, just one dividend of your AMA membership. The Archive-Library services to members include conducting medical literature searches and compiling bibliographies free of charge. Another available aid of great value, the Library's photocopy service, is also free to you. Any article from any journal to which the Library has access can be copied and sent to you for your files.

The Library handles from 1,500 to 1,800

requests similar to those above for information and publications from physician members every month.

Questions and requests may range from the treatment of chlorine inhalation or statistics on human longevity to the latest treatment for Scleroderma or Raynaud's Disease to plans for the mass treatment of large numbers of burned patients.

The AMA Archive-Library upholds the traditional role of the medical library as an adjunct to the postgraduate education of the physician in practice, but it is even more than a library. It is a complete information center.

As a national medical society library, the Archive-Library is able to provide services not normally available on the local level. A more complete collection of materials allows the Library to supplement local library service. In addition, several special subject collections cover thoroughly such topics as international health, history and the sociology and economics of medicine. The AMA's collection on the sociology and economics of medicine is the best in the world. It contains almost all the English language publications and includes opinions reflected in mass media as well as in scholarly works.

At the core of the Library is a collection of current medical publications. Today, 2,200 journals are received on a regular basis. This is twice the number contained in any average medical school library. These represent all the major publications in medicine and the allied sciences. In addition to the periodicals, the Library contains 40,000 books. This makes the Archive-Library one of the most complete current medical libraries you will find any place.

Of course your needs and requests de-





termine the Library's content. The quantity and type of periodicals and reference books contained in the Library are guided by your requirements and those of the AMA staff.

Perhaps the one thing above all others which sets the AMA medical Library apart and makes it a true information center is the availability to the Library staff of a unique resource unavailable at many other medical libraries--the professional staff members of the AMA's 20 scientific departments. "The professional staff is here and we can use them," Susan Crawford, director of the Archive-Library, says. "Few other libraries have this type of consultation available. When a doctor writes to us and wants medical opinion or judgment, his question is referred to a consultant on the AMA staff, or to one of many specialists in the country, through the Questions and Answers Department of JAMA."

Such referrals are made in numerous areas such as medical physics, cardiology, psychiatry and drug therapy. Physicians on the AMA staff evaluate information for you before it is ever delivered.

For example, a question on drugs which requires clinical and pharmacological judgment is routed to the AMA's Department of Drugs. The staff in that department can research all available material on the subject and isolate the exact information you need.

The 26 members of the Archive-Library staff will go to great lengths to give you the information you need, and they are fully qualified to do so. They are especially trained to communicate with physicians--they speak your language. Half of the staff have graduate degrees in various areas and many have two masters degrees, one in library science and another in a chosen field such as econom-

ics, history or the biological and social sciences.

If you are a history buff, one of the more interesting areas of the Library is the Archive Section which houses documents and artifacts on the history of American medicine and the AMA. If you are at all interested in the progress of organized medicine, in the AMA or in tracing your ancestry or doing other historical research, the Archives hold a wealth of information for you.

The Library is always improving and enlarging its facilities. The last addition to the services was the International Health Section which has made it possible for all of the Library services to follow you, as a member of the AMA, wherever you go, whether it be the remote mountain stretches of West Pakistan, the rain forests of Brazil or a center of Civilization such as Paris.

If you are planning an overseas trip or sabbatical, to set up practice or to attend a meeting or congress, the Library can give you all the information you need on foreign

medical organizations, hospital and medical facilities in various countries, living conditions, what you should bring and the locations of the nearest American physician in any country.

The staff can also furnish you with information on a comprehensive and up-to-date listing of medical meetings outside the United States. After you are situated abroad the Library will continue to provide you with research facilities and photocopy services on specific medical subjects just as they did when you were stateside.

Any of the services of the Archive-Library are available to you by mail, telephone (312-527-1500), TWX (910-221-0300) or in person. Library hours are 8:30 a.m. to 4:45 p.m. Monday through Friday.

Copies of a "Guide to Services of the Archive-Library Department," a 16-page pamphlet, will soon be available through the AMA for your further information on this AMA service.

## *Shadel Hospital*

The setting for the 52-bed hospital is in a suburban area which provides the convenience of close contact with all of the medical facilities of the City of Seattle, combined with the quiet surroundings and peaceful atmosphere of a secluded district.

The design of the hospital for the treatment of alcoholism is both modern and functional and maintains the personal and homelike atmosphere which has been synonymous with Shadel Hospital treatment.

Shadel is now located at 12001 Ambaum  
Boulevard S.W., Seattle. CH 4-8100.

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# ALASKA Medicine

Volume 9, Number 2

Summer 1990





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# JACK W. GIBSON, M.D.

1924-1967

By Henry Wilde, M.D.

The sudden death of Jack W. Gibson of coronary thrombosis during a brief vacation in Seattle on July 16, 1967 not only deprived Juneau of one of its pioneer physicians but brought to an end a definite epoch of Juneau Medicine. Doctor Gibson was the last remaining founding member of the New Juneau Clinic; together with Doctors W. Blanton, C. C. Carter and W. Whitehead who had passed away previously. Design and organization of the Juneau Clinic building at 188 South Franklin Street in 1957 was to a large extent his work. The high standard of practice at this institution was not to a small measure due to his continuing interest in clinical and laboratory advances. Though mainly a pediatrician and as such a "doctor's doctor", Jack was also interested and active in the broad field of medicine. He was instrumental in organizing in 1959 a University of Washington affiliated clinical clerkship program at St. Ann's Hospital, Juneau which resulted, for some time, in close liaison with that excellent institution. His interesting pediatric case presentations at St. Ann's Hospital staff meetings, especially in the years 1959-63, will be recalled by his friends and associates, for most of whom he also served as a devoted family pediatrician.

Doctor Gibson was an Oregonian, born in 1924 and educated at Willamette College at Salem and Creighton University School of Medicine, Omaha, Nebraska. He served a short time in the U.S. Navy at the end of World War II and had postgraduate training

at Providence Hospital, Portland and later at the Royal Institute of Child Health, Great Ormond Street Hospital, London, where he was awarded the Diploma in Child Health. Jack held many honorary offices in medical organizations, among which were: Secretary of the Alaska Board of Basic Science Examiners, Councilor of the Alaska State Medical Association, Director of the Division of Maternal and Child Health of the Alaska Division of Health and Welfare, President of the Juneau and District Medical Society and of St. Ann's Hospital Medical Staff.

Doctor Gibson's private life was not without tragedy. His youngest son Shawn died suddenly of vomiting and aspiration while Doctor Gibson was making a house call. His first wife Virginia, whom he married as a College Student, and who was one of Juneau's most beloved matrons, died in 1962 of the syndrome of bone marrow aplasia following infectious hepatitis. His second marriage ended in divorce but he was able to establish once more a happy home for his 3 remaining sons Randy, Dena and Dilan when, in September of 1965, he married Nola Kathleen Roberts, a Juneau teacher and Social worker.

Jack W. Gibson will not so soon be forgotten. He was a man who, along with such pioneer physicians as Simpson, Daws, Council, Clemens, Blanton, Carter and Whitehead, left a lasting imprint on the Juneau scene and in the minds of his many friends, patients and colleagues.



# ALASKA STATE MEDICAL ASSOCIATION

By Robert B. Wilkins, M.D.  
*President*

## Fairbanks Flood

As this issue of Alaska Medicine goes to press, very little information is available regarding the doubtless harrowing experiences that our fellow physicians in Fairbanks have endured since the disastrous flood of August 17th. Our hats are off to these men and women. Despite the flooding and evacuation of St. Joseph's Hospital, and the inundation of a majority of the medical offices in the community, they have been able to cope with their problems in a quiet, and apparently, a remarkably efficient manner. Dr. Frank Nicholas of Anchorage, chairman of the ASMA Committee on Emergency Care and Civil Defense, visited the flooded city on an early Air National Guard flight. He learned from Dr. Ancel Earp, President of the Fairbanks Medical Association, that recruitment of medical aid from other communities was not necessary. Nevertheless, I feel certain that I speak for all ASMA members in offering whatever assistance may be needed to our Fairbanks compatriots.

\* \* \* \* \*

## Committee Appointments

Following is a list of the ASMA committee appointments for the current year. Most appointments were made on the basis of the member's expressed preference. In some cases this was not possible, as certain committees and chairmanships were especially popular. Each committee will be mailed notification of its appointment and responsibilities, as well as its budgetary appropriations.

## Voluntary Health Organizations Committee

Grace Field, Juneau, Chairman  
Paul Isaak, Soldotna  
John L. Noyes, Fairbanks  
Joseph Riederer, Juneau

## Legislative Committee

John Dalton, Juneau  
James W. Mortensen, Ketchikan  
J. Ray Langdon, Anchorage  
Herbert James, Anchorage  
R. Holmes Johnson, Kodiak  
Paul Haggland, Fairbanks  
James Wilson, Ketchikan  
Charles F. St. John, Anchorage  
Robert H. Shuler, Sitka  
Rodman Wilson, Anchorage

## Occupational Health Committee:

Fred Strauss, Anchorage, Chairman  
Robert Billings, Anchorage  
Stanley Ray, Juneau  
A. N. Wilson, Jr., Ketchikan  
Philip Moore, Sitka

## Constitution and By-Laws Committee:

R. Holmes Johnson, Kodiak, Chairman  
Robert H. Shuler, Sitka  
Edward Spencer, Sitka

## Alaska Medicine Editorial Board:

Duane Coon, Petersburg  
John Dalton, Juneau  
L. David Ekvall, Anchorage  
Theodore Shohl, Anchorage  
Herbert James, Anchorage  
Charles Manwiller, Anchorage  
Charles St. John, Anchorage  
Levi Browning, Palmer

## Para-Medical Liason Committee:

Winthrop Fish, Anchorage, Chairman  
Henry Akiyama, Juneau  
Carl Beck, Anchorage  
Peter Hansen, Soldotna

Emergency Care - Civil Defense Committee:

Frank Nicholas, Anchorage, Chairman  
Paul Isaak, Soldotna  
Arndt von Hippel, Anchorage  
Theodore Shohl, Anchorage  
Grace Jansen, Anchorage

Historical Committee:

John Dalton, Juneau, Chairman  
Grace Field, Juneau  
Edward Spencer, Sitka  
Levi Browning, Palmer

Mental Health Committee:

J. Ray Langdon, Anchorage, Chairman  
Phyllis Smith, Ketchikan  
John Rollins, Anchorage  
R. Holmes Johnson, Kodiak  
John L. Noyes, Fairbanks

Trauma Committee:

Theodore Shohl, Anchorage, Chairman  
Henry Storrs, Fairbanks  
Gary Archer, Anchorage

Tumor Registry Committee:

George Hale, Anchorage, Chairman  
Henry Storrs, Fairbanks  
Theodore Shohl, Anchorage  
James Wilson, Ketchikan  
T. J. Phillips, Sitka  
Fred Strauss, Anchorage

School Health Committee:

John Tower, Anchorage, Chairman  
Frank Nicholas, Anchorage  
Nicholas Deely, Fairbanks  
John L. Noyes, Fairbanks  
Warren Jones, Anchorage  
David R. L. Duncan, Anchorage  
Y. O. Dunn, Anchorage  
R. E. Harrell, Anchorage

Resolutions Committee:

Rodman Wilson, Anchorage, Chairman  
Robert H. Shuler, Sitka  
Henry Storrs, Fairbanks

Rehabilitation Committee:

John Rollins, Anchorage, Chairman  
John Dalton, Juneau  
Glenn Crawford, Anchorage  
Louise Ormond, Anchorage  
John L. Noyes, Fairbanks

Bush Medicine Committee:

Stanley Jones, Haines, Chairman  
Duane Coon, Petersburg  
Warren Jones, Anchorage  
L. David Ekvall, Anchorage  
Arndt von Hippel, Anchorage  
Nicholas Deely, Fairbanks  
Wallace Dunn, Anchorage  
Y. O. Dunn, Anchorage  
Grace Jansen, Anchorage

Public Health Committee:

Glenn Crawford, Anchorage, Chairman  
Nicholas Deely, Fairbanks  
Milo Fritz, Anchorage  
Grace Field, Juneau  
Jean Chapman, Juneau  
David R. L. Duncan, Anchorage  
Levi Browning, Palmer

Public Relations Committee:

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John Dalton, Juneau  
Charles F. St. John, Anchorage  
Alan Homy, Anchorage  
Robert Shuler, Sitka

Medical-Legal Committee:

Robert H. Shuler, Sitka, Chairman  
Henry Storrs, Fairbanks



J. Ray Langdon, Anchorage  
Arndt von Hippel, Anchorage  
Herbert James, Anchorage  
James Wilson, Ketchikan  
Rodman Wilson, Anchorage

#### Professional Insurance Committee:

Charles F. St. John, Anchorage,  
Chairman  
Ralph Carr, Ketchikan  
James Mortensen, Ketchikan  
Henry Storrs, Fairbanks  
Milo Fritz, Anchorage  
James Wilson, Ketchikan  
T. J. Phillips, Sitka  
Robert Shuler, Sitka

#### U. S. Public Health Service

The July visit to Alaska by Dr. William H. Stewart, Surgeon General, Public Health Service, afforded ASMA officers a unique opportunity to meet with a committee of the American Medical Association. Travelling with the Surgeon General was the AMA Committee on Federal Medical Services. This committee, among other responsibilities, maintains liaison for the AMA with the Indian health programs of the U. S. Public Health Service, and was in Alaska as a guest of the Division of Indian Health to review the care provided by the Division in the Anchorage and Bethel areas. Meeting with the committee, in addition to your president, were Dr. Alistair Chalmers, ASMA Secretary-Treasurer, Dr. J. Ray Langdon, Greater Anchorage Regional Councilor, Dr. Elizabeth Tower (representing her detained husband Dr. John Tower, acting Anchorage Medical Society President), Dr. Milo Fritz, Anchorage legislator, and Mr. Robert Ogden, ASMA Executive Secretary.

The meeting afforded the AMA committee the opportunity of discussing the functions of the Indian health program with physicians who are not personally intimately involved with it.

Dr. Fritz gave an eloquent, frank, succinct presentation of his ideas of improving the service, with illustrations. The committee was informed of the ASMA resolutions frequently adopted urging the USPHS Alaska Native Health Service to conduct its activities in a manner more likely to prevent continuing dependence of the native people on government welfare programs. The committee recommended that the ASMA, through its delegate, propose a resolution on this subject for presentation at a future AMA convention.

Members of the visiting AMA committee consisted of Dr. Henry S. Blake, Topeka, Kansas, chairman; Dr. Donald C. Conzett, Dubuque, Iowa; Dr. Robert S. Green, Cincinnati, Ohio; Dr. Herman J. Smith, Des Moines, Iowa; Dr. James D. Weaver, Washington, D. C.; Dr. Milo A. Youel, San Diego, California. Also attending was Mr. James H. Fleming, Secretary of the Committee. This was thought to be only the second occasion on which an AMA committee had visited Alaska.

#### Professional Liability Insurance

The problem of securing professional liability insurance at a reasonable rate, or of securing it at all, continues to be a serious problem for Alaskan physicians despite the passage of S. B. 142 by the Alaska Legislature last spring. Since the passage of this bill, the ASMA office has contacted insurance brokers throughout Alaska as well as in other states, and until quite recently, no company has been willing to quote new rates. The problem has been further compounded by the cancellation of the American Association of General Practitioners professional liability insurance program in Alaska.

A refreshing and welcome change in the picture came in the form of the recent letter sent to every practicing physician in Alaska

by La Bow, Haynes of Alaska, Inc., announcing the availability of liability insurance coverage in Alaska from a new facility, and quoting rates that, although not as favorable as those currently paid by some physicians, are considerably lower than rates paid by many others. Mr. George Suddock, president of the company, is most interested in working toward a group coverage program through the Association. If insurance such as that offered by the La Bow, Haynes Company is favorable

for you both from the point of total coverage and premium rate, an application now might well result in even more favorable rates in the future. I am asking Dr. St. John's Professional Insurance Committee to work closely with Mr. Suddock in an attempt to work out a favorable ASMA group liability insurance program. We cannot count on every member of the Association subscribing to such insurance, but I hope we can count on every member's cooperation with Dr. St. John's committee.



*Robert B. Wilkins, M.D.*





*E. S. Rabeau, M.D., and Joseph Shelton, M.D.*

## **PRESENTATION TO DR. JOSEPH SHELTON**

**By E. S. Rabeau, M.D.**

On occasion, the Division of Indian Health of the U. S. Public Health Service awards a special certificate of appreciation to an individual who has contributed significantly through professional assistance and guidance to the division goal of raising the health of the American Indian and Alaska Native to the highest possible level.

Tonight, I have the honor to present this certificate to Dr. Joseph Shelton, who has given so unselfishly of his time and talent in the field of sight preservation and restoration for the benefit of the Alaska Native.

He has faithfully supported the division of Indian health as a consultant from the very beginning in 1955, devoting hours of his time to the clinical and surgical treatment of the native beneficiaries far beyond the normal duties or expectations.

Without his able assistance over the years, many an Alaska Native could not have seen to hunt for food, his wife could not have seen to sew; and his children could not have seen to read and learn.

In the early days when our staffing at the

Anchorage hospital was so limited, he was regularly on call. And, it was through his excellent teaching that our field physicians learned refraction techniques. His three day ophthalmology course is something of a legend among those physicians who have worked in Alaska at the service unit level. He is still providing his expert consultation.

Dr. Shelton epitomizes the great services we receive from our many excellent professional consultants, and, as we pay homage to him, we are also acknowledging a debt to all these fine men who give so unstintingly of their time and knowledge. Our program would suffer without them.

I feel especially privileged to be able to express the Public Health Service's appreciation to Dr. Shelton, for I am personally very well acquainted, over a long number of years, with his deep compassion for his patients and with the extensive contributions he has made to the Alaska Native health program.

Dr. Shelton--this award is made only to a few. Please accept it with our most sincere gratitude.

# WHITE SHY

By Father Paul C. O'Connor, S. J.

Father Paul C. O'Connor, S. J. received his A. B. and M. A. from Gonzaga University, Spokane, in 1921 and 1923. After post graduate work at Fordham University Father O'Connor studied two years at Heythrop College in England and two more years in France. Since coming to Alaska in 1930 Father O'Connor has travelled all over Northern Alaska by dog-team, boat, and plane. In two separate 6 year terms as Superior of St. Mary's School on the Yukon Father O'Connor helped start the first high school on the Yukon. Later he also served as Superior at the Copper Valley School. For 14 years Fr. O'Connor was a Commissioner of the Alaska Housing Authority. During twelve of these years he was Chairman of the Board. At various times he has been postmaster of isolated communities and during W.W. II he was the weatherman at Kotzebue. Father O'Connor has written many articles and one book (Eskimo Parish) about Alaska and currently is completing another book.

Isolation plays some queer tricks with our mentality. This happens no matter how well we think we can stand the rigors of this stern Northland. The Oblate Missionaries of Northern Canada have made it a rule for their members never to remain for any length of time completely alone. We Jesuits have something to learn from these capable missionaries. Probably it is for this reason that our Superiors have insisted that isolated missionaries report at stated periods to one of our larger missionary communities.

Any missionary or school teacher who lives completely surrounded by Indians or Eskimos in far flung districts sooner or later finds himself engulfed in the mentality of those that he lives with. He must make a special effort to dress properly and keep a regular schedule. Nobody is around to check. Blizzards sometimes last for days without anyone coming near him. On these days he must be ingenious in keeping himself busy and following a planned ritual of the day. I know one good teacher who summarily dismissed class on just such a day. During a break in

the weather a school inspector dropped from the skies to find the teacher calmly butchering a reindeer in the middle of the classroom.

After months or years in a secluded district without much communication with the outside world there develops a state of mind which I might call "white-shy". The person in question not merely avoids meeting white people, but when he is in their company he becomes timorous and uncommunicative. When he comes to town he has an actual fear of using the telephone. In this respect he resembles many natives who have a real mental block in talking over the telephone.

Old sourdoughs who travel "Outside" to see the sights soon tire of them. They withdraw to their hotel rooms and do not even call up friends who would like to see them. They feel strange in sitting down in a busy restaurant and ordering their meals. One when asked what he was worrying about, said "I am worrying about that pet weasel in my cabin. No one is around to feed him!" After a few days he hustled back to his peace and quiet.

One of the signs of maturity is adjustment to things, places, and persons. Some people feel that they will never adjust to the hustle and bustle of a modern city. They run off to the hinterland. Others are fugitives either from the law or from the pressures of their own relatives. Psychologists may call this escapism, but to my mind this is oversimplification. Many of these people are not really anti-social, but weary of either individuals or the government intruding on their privacy. The mind of man is as mysterious as ever. Some would rather think than speak. To do this they cherish not so much isolation as freedom from noise and distracting time schedules.



Many teachers go off to the bush to make a little grub-stake. Little by little they become involved in the needs of their tiny community. They come to feel that they are wanted and needed, and finally end up with a real commitment to their absorbing community. Most missionaries come because they are sent. Their hidden ideal is to literally follow the injunction of Our Lord to his apostles: "Go forth and teach". However living alone or with a very few does not fit in with some personalities. Superiors of course do screen their men, but the human factor of error is always present. Then, as one remarked to his Mission Superior, "My ill health could be settled by a one way trip to Seattle".

I visited one family of teachers in a lonely Arctic village. I saw that the stern code of the Northland was too severe, both for them and their little children. I advised them to get out of the country as soon as possible. They did and were extremely grateful for the advice.

Homesteaders are a breed all their own. They come to stay. Many have large families, work hard, enjoy hunting and fishing, and incidentally, keep good social contacts with their neighbors. A sixty mile round trip for a bridge party means nothing to them. Few of these people suffer from the affliction of being "white-shy". Rather they are out-going and garrulous.

The "white-shy" group is found living in a completely native surrounding. They tend to adopt the customs of the native village. Their communications are confined to the speaking level of the natives about them. Unconsciously they adopt their habits.

When these people come to town their

shoes are unshined, their clothes unpressed. Their general appearance is out of style. They revert to topics of conversation that are completely parochial. At first the oddity of their manner does not strike home, but almost in a day they begin to realize that they are out of the swim and become self-conscious. They become timorous and withdrawn. New clothes are not available. They long to return to the peace and quiet of their village.

We call their plight escapism. They call us image carriers, not masters of our own lives, economic worriers - tax collectors and pharisees!

They maintain, and sometimes not without reason, that the natives take people as they are. City communities do tend to emphasize the image of a profession rather than the all important individuality of a person. True communication is definitely a person to person contact. Sheer professionalism diminishes more and more the easy charm of a personality.

Before we condemn these so-called escapees let me end by a thought I recently read from the work of a French Psychiatrist - Henri Samson. The thought comes to this: when someone flatly and with a quiet smile contradicts us - the objectivity that we think we have crumbles away. We are still too petty and limited for the Spirit of God to enlarge our heart and broaden our mind. Instead of His Spirit - it is our own we want to defend. Dedication to our own profession may only too often be blended with our own craving for domination.

(Rev.) Paul C. O'Connor, S. J.

Chaplain, Providence Hospital,  
Anchorage, Alaska

# ALASKA NATIVE INFANT HEALTH PROBLEMS

By **Bale S. Gurunanjappa**

*Chief, Program Analysis Branch,  
Alaska Native Health Area Office, Anchorage, Alaska  
U.S. Department of Health, Education, and Welfare  
Public Health Service, Division of Indian Health*

## Introduction

This paper deals with the health problems of Alaska Native infants. Alaska Natives consist of three main ethnic groups: Eskimos in the northern and western areas, Indian in the southeastern and central interior part of Alaska, and the Aleuts in the Aleutian Chain region. Most of the Natives are self-employed in fishing, trapping, and hunting. In urban areas like Anchorage, Fairbanks, and in some rural parts, a substantial number of Natives are employed by Federal and State agencies. In 1965, the Bureau of Indian Affairs estimated that based on the natural increase, there were 51,300 natives in Alaska. This represents a 16% increase over the 1960 census figures. Most of the Native population is under the age of 25 years, 46% less than 15 years, 19% less than five years, and 4% under one year of age.

## Background

Hayman and Kester<sup>1</sup> in their "Study of Infant Mortality in Alaska" report a Native infant mortality rate of 87 per 1000 live births (1950-55), two times higher than for all races of Alaska combined (41.6) and 3-1/2 times higher than the White (24.6). During the same period, Bethel area (Bethel and Wade Hampton districts) in western Alaska had an infant mortality rate of 156-159. They conclude that the infant mortality among whites in Alaska is no higher than in the rest of the United States, but that it is excessive among the

Native races. The causative factors for excessive infant mortality among Natives include isolation from medical and allied facilities, poor economy, cultural lag, low level of general and health education, and primitive knowledge of hygiene and sanitation. All of these factors must be attacked to reduce morbidity and mortality among Native children.

Hammes<sup>2</sup> in a household survey of 24 Eskimo villages based on 902 households in the Bethel area reported a median household size of 5.9, an average of 3.8 person per room and with an average of 2.2 persons per bed. Further, about 2,800 persons lived in dwellings providing 300 cubic feet or less space (not free space) per person.

## Natality

There were 2,084 Native births registered in 1965 as compared to 2,111 in 1961. The crude birthrate for Natives, 40 per 1000 population, is twice the United States rate (19.4 per 1000 population), and 1-1/2 times the Alaska Non-Natives birthrate (25.9 per 1000 population). The Native birthrate has decreased in recent years (figure 1). The Bethel area accounts for the largest number (average 485 births per year 1962-65), of Native births in Alaska with a rate of 45 per 1000 population, while the Barrow area in the northern Alaska has the highest birthrate (55 per 1000 population).

In 1965, 85% of the total registered Native births occurred in hospitals compared to 69%



## BIRTH RATE per 1,000 POPULATION

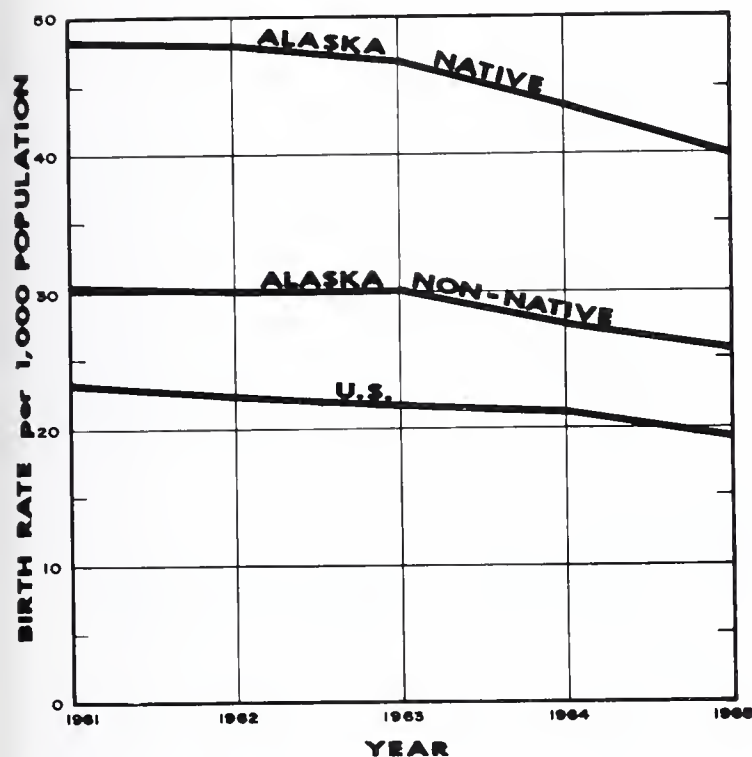


FIGURE 1

## PERCENT ALASKA NATIVE HOSPITAL AND NON - HOSPITAL BIRTHS 1961 - 1965

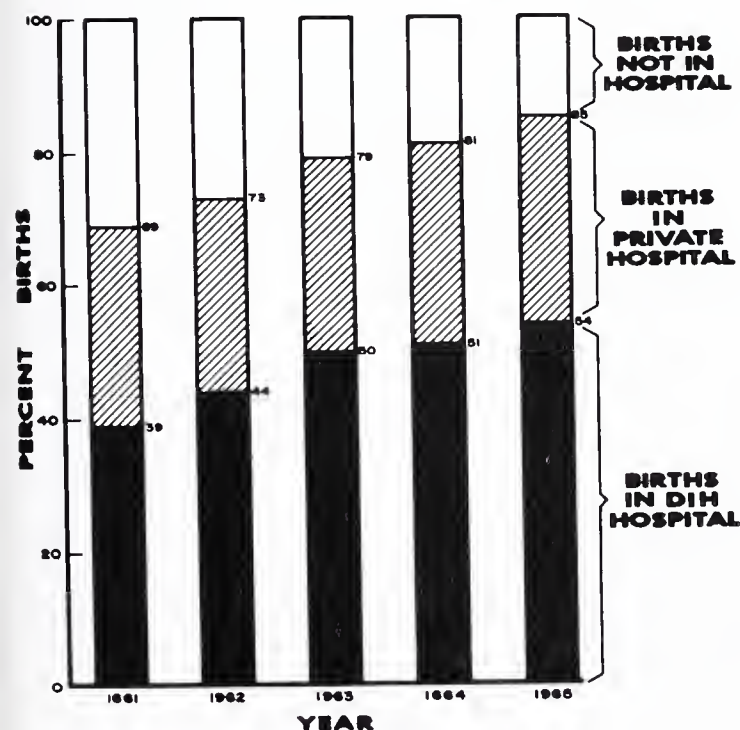


FIGURE 2

in 1961 (figure 2). Public Health Service facilities being the major source of hospitalization, most Native deliveries occur in these hospitals. -64% of the hospital births and 54% of the total births. The number of deliveries occurring in these facilities varies according to the size of the service population. The proportion of Natives births occurring in private facilities has remained constant at about 30%.

## Morbidity

In fiscal year 1965, 9,263 patients (excluding newborns) were discharged from the seven Public Health Service Hospitals; 899 or 9.7% were infants. This represents an increase of 21% in infants discharged compared to the previous fiscal year. The leading causes for infant hospitalization were influenza and pneumonia (27%), and gastroenteric diseases (13%). The figures were 36% and 10% respectively in FY 1964 (figure 3). Respiratory diseases, gastroenteric diseases, and otitis media are the leading causes among

## PERCENT INFANT DISCHARGES FROM PHS ALASKA NATIVE HOSPITALS BY DIAGNOSIS

FISCAL YEARS 1961-1965

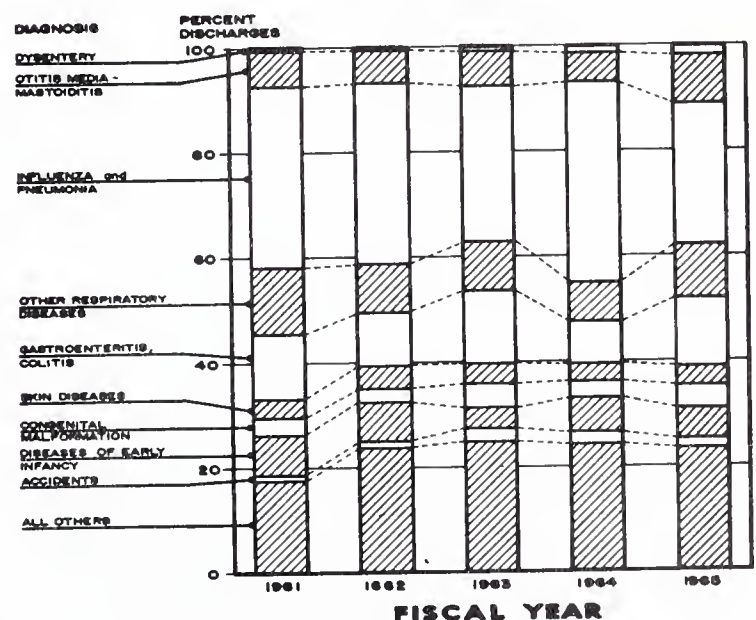


FIGURE 3

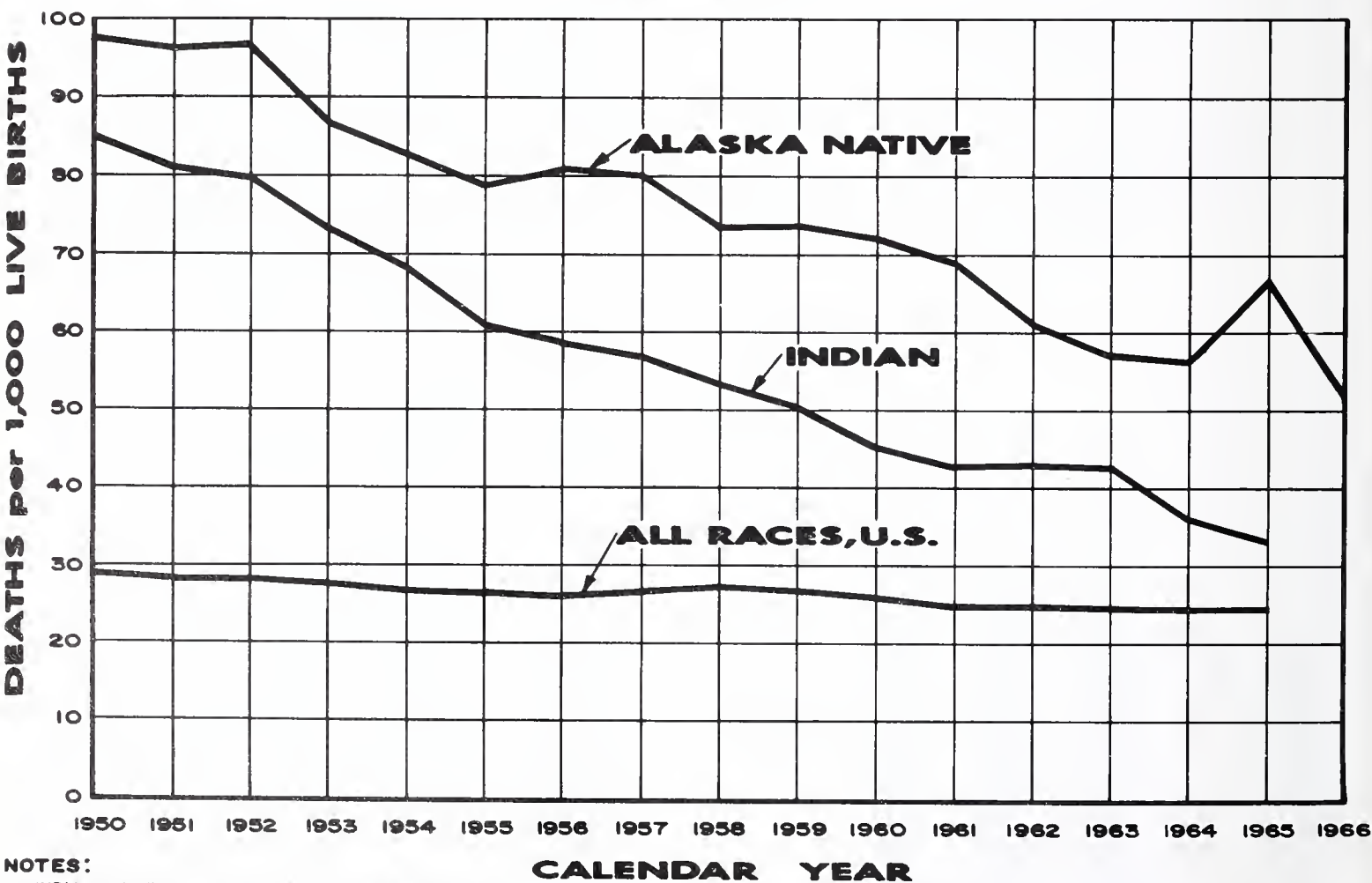
8,300 infant outpatient visits in FY 1965. The number of infant outpatient visits increased by 4% in FY 1965 compared to FY 1964.

Mortality

Alaska Native infant mortality rates (neonatal and postnatal) have been considerably higher than the Indians (lower 48 States) and United States rates. In 1965, the neonatal death rate was 23 per 1,000 live births, compared to 18 per 1,000 live births in the United States--1-1/3 times higher. The Alaska Native postnatal mortality rate was 44 com-

pared with 7 for the United States--6-1/2 times higher. In 1964, the Alaska Native neonatal death rates were 1-1/2 times higher than Indian rates and 1-1/3 times higher than United States rates. Postnatal rates were 1-3/4 times higher than Indian rates and 5 times higher than United States rates. Alaska Native infant mortality rates show a downward trend from 1950 through 1964 (figure 4). However, the 1965 rate was higher than in 1964. For the five year period 1960-65, the annual average infant mortality rate was 61 per 1,000 live births compared to 87 for 1950-1955<sup>1</sup>. It is interesting to observe that in 1965 the

**INFANT MORTALITY RATES  
INDIAN, ALASKA NATIVE AND ALL RACES, U.S.  
1950 - 1965**



NOTES:  
INDIAN RATES: SINGLE YEAR FOR 1963, 1964, 1965  
ALASKA NATIVE RATES: SINGLE YEAR FOR 1965  
INDIAN RATES: 3 YEAR MOVING AVERAGES 1950-1962  
ALASKA NATIVE RATES: 3 YEAR MOVING AVERAGES 1950-1964  
U.S. ALL RACES: ALL SINGLE YEARS

PREPARED BY PROGRAM ANALYSIS BRANCH  
ALASKA NATIVE HEALTH AREA OFFICE

FIGURE 4



# INFANT MORTALITY RATE by CAUSE OF DEATH ALASKA NATIVE and UNITED STATES

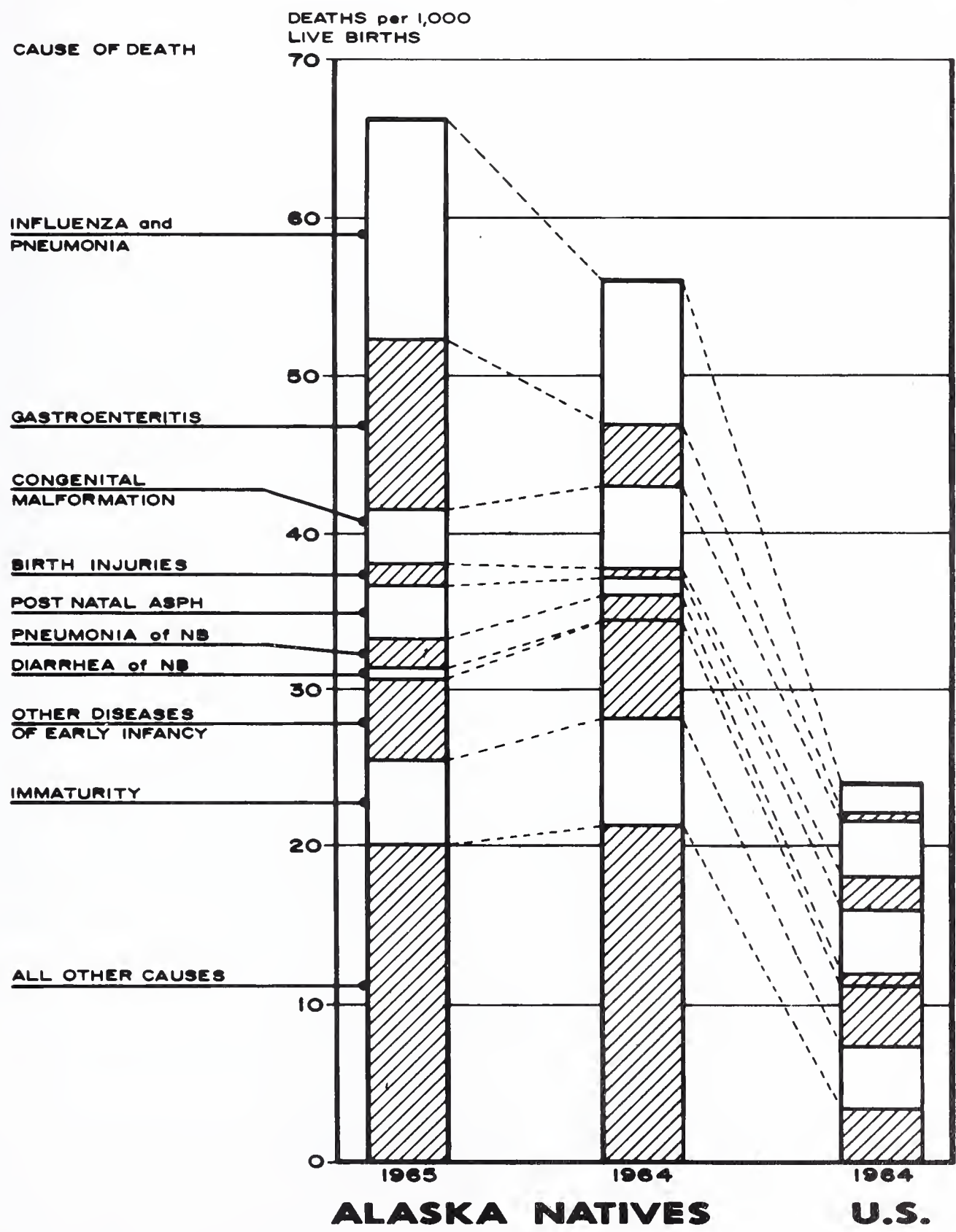


FIGURE 5

Bethel Area had a neonatal mortality rate of 21 per 1,000 live births and a postnatal mortality rate of 126 per 1,000 live births. Excluding the Bethel service area, the Native infant mortality drops from 66 to 42 per 1,000 live births, and is reduced from almost 3 to less than 2 times the United States.

### Discussion

Alaska Natives are more aware of their health needs though they continue to live far from medical facilities. This has contributed to the increased outpatient and inpatient workloads of the Public Health Service and private hospitals and clinics. In FY 1965, the number of hospital admissions to Public Health Service hospitals increased by 38% and outpatient visits by 5% compared to FY 1960. Also each Public Health Service hospital received 6-15 radio calls each day from villages seeking medical advice.

Alaska Natives have a high birthrate--two times the United States rate--and high infant mortality--1-1/2 times higher in neonatal period and 6-1/2 times higher in post natal period as compared in United States rate. Alaska Native infant mortality rate has decreased in recent years and also shows a downward trend which might be attributed to the health awareness among the Native people, increase in hospital deliveries, and the prevention of certain infectious diseases through the field health program. To accelerate this decline further, many preventive programs

are being implemented or expanded by the Federal and State agencies involved. These include immunization against infectious diseases, increased emphasis on health education, field health activities, pre and postnatal care, family planning, nutritional education, and construction of sanitary facilities.

### Summary

Alaska Native infants have a high mortality rate as compared to U.S. population. Progress has been made in reducing the high Native infant mortality rate. We might anticipate that the greater health awareness of the Native people together with the increased emphasis on preventive programs by Federal and State agencies involved will accelerate this downward trend of Native infant mortality in the near future.

Definitions: Neonatal period is the first 28 days; Postnatal is 28 days to one year; Infant is up to 1 year old.

Editor's Post Script: In 1966, the birth rate for Alaska Natives was 39 per 1,000 population. The infant mortality rate was 52.5 per 1,000 live births. It is interesting that these figures are considerably below the previous year. It is probably due to the prevention or absence of any major epidemics affecting infant mortality. Further, the Bethel Area has reduced their infant mortality by 54% (147.3 in 1965; 68.3 in 1966) compared to the previous year.

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# RELATIONSHIP OF ANEMIA TO INFECTIOUS ILLNESSES ON KODIAK ISLAND

By

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## Introduction

A higher frequency of respiratory infections in infants who are anemic due to iron deficiency has been reported in a controlled study by Andelman and Sered. (1) This relationship was reported in both 1928 and 1932 by MacKay. (2,3)

Arctic Health Research Center investigators conducted similar studies in Bethel in 1960 and 1961. (4)

Their findings indicated that infant anemia is common and that 47% of the reported illnesses in those children studied were respiratory. It was also found that 85% of the illnesses reported were infectious. A study by Brody, in the same Bethel area, emphasizes the high frequency of lower respiratory infections among native children. (5). USPHS Division of Indian Health statistics for 1965 in Alaska indicate respiratory illnesses, not including tuberculosis, to be the leading cause of hospitalizations and deaths in children from birth to four years of age. (6) Infectious diseases were the second highest cause of deaths for the same age range and year. (6)

To study the possible relationship between anemia and infectious illness, all children under three years of age in the following Kodiak island villages were evaluated: Ahkiok, Karluk, Larsen Bay, Old Harbor, Ouzinkie, and Port Lions. All six villages were provided medical care by the Alaska Native Medical Center in Anchorage, on periodic field

clinics (twice yearly) conducted jointly by a staff physician from the Medical Center and the Kodiak Island Public Health Nurse. Previous observations of both hospital and field clinic hemoglobin determinations had suggested that iron deficiency anemia was related to childhood illnesses in these Kodiak villages.

## Materials and Methods

A regularly scheduled field clinic was conducted in late November through mid-December 1966 on Kodiak island. Each of six villages listed was visited and general medical and preventive care was provided by the authors. A history was obtained for each child born between November 1963 and November 1966. Information sought on each child included birth date, birthplace, birth weight, gestational age at birth, maternal parity, iron and/or vitamin supplementation for the child, the types and number of illnesses of each child, and pre-natal iron and/or vitamin supplementation for the mother. Field and hospital records, when available, were studied to supplement clinical histories.

Mothers and other adult village residents were questioned about food supplies for each village. These questions specified availability of wild game, sea food, garden foods, wild vegetables and fruits, and cannery and village foods.

Hemoglobin determinations were done in

each village by the Kodiak Public Health Nurse. A Spencer Hemoglobinometer was used for all determinations. The hemoglobin determinations were done at the same time as the histories and examinations.

Results

In the six villages studied, there were 82 children 3 years and under. Seventy-eight (95%) of these children were present and studied. The average hemoglobin for all 78 children was 10.3 grams %. Village averages are given in Table 1.

Table 1. Average Hemoglobin Values of Children Aged 0-3 Years by Village

Village	Number in Study	Average Hemoglobin Level
TOTAL	78	10.3 gms %
Ahkiok	14	11.1 gms %
Karluk	6	9.9 gms %
Larsen Bay	6	9.3 gms %
Old Harbor	23	9.6 gms %
Ouzinkie	18	10.5 gms %
Port Lions	11	10.9 gms %

The children were divided into 4 groups according to age. The average hemoglobin levels for all villages within these age groups are shown in Figure 1. The expected normal hemoglobin levels (from Nelson, Textbook of Pediatrics) for the same age ranges are also shown.

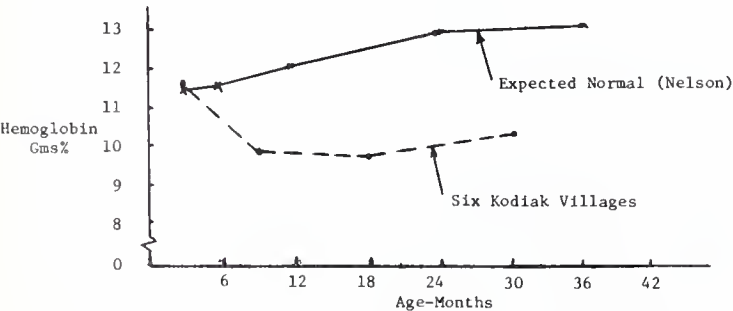


Figure 1. Average Hemoglobin Levels by Age Distribution

A comparison was made between the children's hemoglobin levels and their supplemental iron history. Each village group was divided into those who had no iron supplementation, those who had received from 1 to 3 months of oral iron at any time, and those who had received 3 months or more of oral

iron at any time. Also included in the third group were children who received intramuscular iron injections during hospitalizations and 1 child who had been given one blood transfusion. These results are shown in Table 2.

Table 2. Iron Treatment in Children

Village	No Iron	1-2 Months Oral Iron	3 Months Oral Iron, I. M. Iron or Transfusion
Ahkiok	6	5	3
Karluk	3	2	1
Larsen Bay	3	3	0
Old Harbor	11	6	6
Ouzinkie	12	5	1
Port Lions	9	1	1
TOTAL	44 (56%)	22 (28%)	12 (16%)
Average Hemoglobin	10.4 gms%	9.6 gms%	11.3 gms%

The effect of vitamin supplementation on hemoglobin levels was used as a control for the iron treatment results. (Table 3)

Table 3. Vitamin Supplementation in Children

Village	No Vitamins	1-2 Months Oral Vitamins	3 Months Vitamins
Ahkiok	9	5	0
Karluk	3	2	1
Larsen Bay	3	1	2
Old Harbor	10	8	5
Ouzinkie	9	4	5
Port Lions	2	3	6
TOTAL	36 (46%)	23 (29%)	19 (25%)
Average Hemoglobin	10.5 gms%	10.1 gms%	10.2 gms%

Calculations were made to determine if the number of serious illnesses could be correlated with hemoglobin levels. A serious illness was defined as a documented episode of otitis media, pneumonia, diarrhea or serious upper respiratory infections requiring hospitalization. The children were divided into four categories, determined by whether a child's hemoglobin was above 10.5 grams % or equal or below 10.5 grams % and by the number of serious illnesses reported. Children with hemoglobin above 10.5 grams % averaged 13.5 months in age, compared with an average age of 17.5 months for children with hemoglobin equal or less than 10.5 grams %. Chi square testing of this data with one degree of freedom yielded a (Probability) of 0.01.



## Summary

Table 4. Illnesses Correlated With Hemoglobins

No. Children With	Hgb. Above 10.5 gms%	Hgb. Equal or Less than 10.5 gms%
Two Illnesses or less	20	20
Greater than two illnesses	6	32

## Discussion

A higher frequency of respiratory infections in infants who are anemic due to iron deficiency has been reported in several studies. (1,2,3) Schulman has demonstrated that all infants, regardless of socioeconomic status, are susceptible to iron deficiency anemia unless exogenous iron is provided by dietary or other means. (7) Sturgeon has reported the iron requirement for term babies to be 156 mg. for the first year of life (0.43 mg./day) and for prematures to be 238 mg. (0.65 mg/day). (8) Schultz and Smith have shown that approximately 10% of iron available in milk, enriched cereals, and eggs is absorbed in the human intestine. (9)

This study demonstrates iron deficiency anemia to be common among the native children in 6 Kodiak island villages. Supplemental oral iron for greater than 3 months or intramuscular iron was shown to raise average hemoglobin levels in anemic children by 1.7 grams %. By comparison no increase in hemoglobin was found with vitamin supplementation. The duration of supplemental oral iron is crucial if sufficient iron is to be provided for children with iron deficiency. Native children taking liquid oral iron preparation (25 mg. elemental iron/cc) for 3 months receive approximately 135 mg. of iron or 87% of the average first year requirements.

Analysis of the children with more than 2 serious illnesses (see Table 4) revealed the predominance of respiratory illnesses. Twenty-four of the 32 anemic children had respiratory illnesses only.

Seventy-eight children from birth to 3 years of age in 6 villages on Kodiak Island were studied to determine if a relationship existed between iron deficiency anemia and serious illness. The average hemoglobin of these children was 10.3 grams %. Those children who had been treated with oral iron for 3 or more months had a hemoglobin level 1.7 grams % higher than those given iron less than 3 months. Serious illnesses appear to be correlated with iron deficiency anemia in these children. It appears that adequate oral iron supplementation to Alaskan native infants will help decrease the frequency and degree of serious illnesses. The findings of this study suggest that further evaluation of the medical, preventive, and nutrition education services for Kodiak island villages is indicated.

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• GLENNALLEN--2P

ANCHORAGE--80P36U64M9S1B •

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KANAKANAK

PHS Alaska Native Hospital  
99567

Daniel J. O'Connell, M.D., Service Unit Director  
R. L. Lorenzo, M.D.  
Jordan Holloway, M.D.

KETCHIKAN

PHS Alaska Native Health Center  
99901

Stanley Yoder, M.D., Health Clinic Director  
Ronald E. Tinsley, M.D.

KOTZEBUE

PHS Alaska Native Hospital  
99752

Richard T. Light, M.D., Service Unit Director  
L. G. Dillon, M.D.  
Harry L. Owens, M.D.

MT. EDGE CUMBE

PHS Alaska Native Hospital  
99835

George N. Wagnon, M.D., Medical Director  
Daniel Failoni, M.D.  
J. B. Deck, M.D.  
Edson F. Deal, M.D.  
John R. Herd, M.D.  
Peter E. Cannava, M.D.  
Charles D. Coln, M.D.  
Robert R. Thompson, M.D.  
Mary J. Brand, M.D.

ST. GEORGE ISLAND (PRIBILOF ISLANDS)

PHS Alaska Native Hospital  
99660

Holm Neumann, M.D., Medical Officer in Charge

TANANA

PHS Alaska Native Hospital  
99777

J. K. Jones, M.D., Service Unit Director  
Charles C. Carr, M.D., Assistant Director

DEPARTMENT OF HEALTH AND WELFARE PHYSICIANS

ANCHORAGE

Tower, Elizabeth A.  
Koutsky, Carl D.  
Rollins, J. P.  
Ahlem, Judith  
Granat, Henry G.  
Hooker, Keith R.  
Johnstone, Bruce B.  
O'Brien, Aloysius V.

Southcentral Regional Health Officer  
Director, Alaska Psychiatric Institute  
Chief, Psychiatric Services  
Regional Mental Health Clinic  
Alaska Psychiatric Institute  
Tuberculosis Consultant  
Alaska Psychiatric Institute  
Alaska Psychiatric Institute

JUNEAU

Chapman, W. J.  
\* Cavitt, Robert F.  
Reddy, D. V.  
Gorton, Virginia  
Lesh, Jack K.

Commissioner  
Director, Public Health  
Director, Child Health  
Mental Health  
Welfare



## FEDERAL AVIATION ADMINISTRATION

Wendell C. Matthews, M.D.

632 Sixth Avenue  
Anchorage, Alaska 99501

John E. Hepler, M.D.

632 Sixth Avenue  
Anchorage, Alaska 99501

## VETERANS ADMINISTRATION

Richard Kraft, M.D.

P.O. Box 1288  
Juneau, Alaska 99801

Grace Field, M.D. (Retired)

Box 813  
Juneau, Alaska 99801

## ANCHORAGE BOROUGH HEALTH CENTER

Duncan, David R. L., M.D.

Anchorage Borough Health Officer

## NUMBER OF MILITARY PHYSICIANS BY SPECIALTY

### United States Air Force

1. Headquarters, Alaskan Air Command, Elmendorf AFB, Alaska:
  - a. Administrative and Staff Medicine 2
2. USAF Hospital Elmendorf, Elmendorf AFB, Alaska:
  - a. Administrative and Staff Medicine 1
  - b. Aerospace Medicine 7
  - c. General Practice 3
  - d. Pediatrics 4
  - e. Internal Medicine 4
  - f. General Surgery 4
  - g. Urology 2
  - h. Ophthalmology 2
  - i. Otolaryngology 2
  - j. Orthopedic Surgery 3
  - k. Obstetrics and Gynecology 4
  - l. Cardiology 1
  - m. Dermatology 1
  - n. Allergy 1
  - o. Neurology 1
  - p. Psychiatry 4
  - q. Pathology 1
  - r. Radiology 2
  - s. Anesthesiology 2
3. 5010 USAF Hospital, Eielson AFB, Alaska:
  - a. Aerospace Medicine 4
  - b. General Practice 2
  - c. Pediatrics 1
  - d. Internal Medicine 1
  - e. General Surgery 1
4. 5073 USAF Dispensary, Shemya AFS, Alaska:
  - a. Aerospace Medicine 1
5. 5074 USAF Dispensary, Wildwood AFS, Alaska:
  - a. General Practice 2

### United States Navy

1. Station Hospital, U. S. Naval Station, Kodiak, Alaska:
  - a. Aerospace Medicine 2
  - b. General Practice 1
  - c. Obstetrics and Gynecology 1
  - d. General Surgery 1
  - e. Internal Medicine 1
2. Station Hospital, U. S. Naval Station, Adak, Alaska:
  - a. Aerospace Medicine 1
  - b. General Practice 2
  - c. Obstetrics and Gynecology 2
  - d. General Surgery 1

### United States Army

1. Headquarters, U. S. Army Alaska, Fort Richardson, Alaska:
  - a. Administrative and Staff Medicine 1
  - b. Preventive Medicine 1
2. Bassett Army Hospital, Fort Wainwright, Alaska:
  - a. Administrative and Staff Medicine 1
  - b. Aerospace Medicine 1
  - c. General Practice 8
  - d. Pediatrics 2
  - e. Internal Medicine 2
  - f. General Surgery 2
  - g. Orthopedic Surgery 1
  - h. Ophthalmology 1
  - i. Obstetrics and Gynecology 3
  - j. Radiology 1
  - k. Psychiatry 1
  - l. Pathology 1
3. Dispensary, Fort Richardson, Alaska:
  - a. Aerospace Medicine 1
  - b. General Practice 8
  - c. Internal Medicine 2
  - d. Pediatrics 1
  - e. Psychiatry 1
4. Dispensary, Fort Greely, Alaska:
  - a. General Practice 2

## ARCTIC HEALTH RESEARCH LABORATORY—FAIRBANKS

Maynard, James E., M.D.

Boyd, David L., M.D.

Noble, Gary R., M.D.

Lyons, Richard, M.D.

## ALASKA STATE BOARD OF MEDICAL EXAMINERS

### PRESIDENT

H. I. Akiyama, M.D.

1420 Glacier Avenue

Juneau, Alaska 99801

### SECRETARY - TREASURER

James A. Wilson, M.D.

Box 2577

Ketchikan, Alaska

### ANCHORAGE BOARD MEMBER

Charles St. John, M.D.

207 E. Northern Lights

Anchorage, Alaska 99502

### NORTHERN BOARD MEMBER

Harold Bartko, M.D.

P. O. Box 550

Nome, Alaska

### FAIRBANKS BOARD MEMBER

Raymond D. Evans, M.D.

Box 1330

Fairbanks, Alaska

## POISON CONTROL CENTERS OF ALASKA

ANCHORAGE—Alaska Native Medical Center, Box 7-741

FAIRBANKS—Northward Drug, Box 1207

JUNEAU—St. Ann's Hospital, 419 6th Street, Information Center Only

KETCHIKAN—Ketchikan General Hospital, 347 Bowden Street

MT. EDGECEMBE—Alaska Native Hospital, Public Health Service



# ALASKA'S HOSPITALS AND NURSING HOMES



1. ADAK (Population 2,613)
  - a. U.S. Naval Station Hospital--26 beds
2. ANCHORAGE (Population 106,800)
  - a. PHS Alaska Native Health Hospital, Box 7-741--340 beds
  - b. Alaska Psychiatric Institute, 2900 Providence Avenue--225 beds
  - c. Anchorage Community Hospital, 825 L Street--45 beds
  - d. Providence Hospital, 3200 Benedict Drive--121 beds
  - e. Ridgeview Manor Nursing Home, Box 3-3871--18 beds
  - f. Woodhaven Rest Home, 309 Fireweed Lane--23 beds
  - g. U.S.A.F. 5005th Hospital, Elmendorf Air Force Base--200 beds
3. BARROW (Population 2,600)
  - a. PHS Alaska Native Health Hospital--12 beds
4. BETHEL (Population 7,000)
  - a. PHS Alaska Native Health Hospital--65 beds
5. BIG DELTA (Population 155)
  - a. Fort Greely Dispensary--2 beds
6. CORDOVA (Population 2,000)
  - a. Cordova Community Hospital--22 beds
7. FAIRBANKS (Population 45,400)
  - a. St. Joseph's Hospital, Box 377--67 beds
  - b. Bassett Army Hospital, Fort Wainwright--192 beds
  - c. Eielson Air Force Base Hospital--20 beds
  - d. Fairbanks Pioneer Home--63 beds
8. GLENNALLEN (Population 300)
  - a. Faith Hospital, Box 5--2 beds
9. HOMER (Population 1,250)
  - a. Homer Hospital, Box 683--6 beds
10. JUNEAU (Population 13,000)
  - a. St. Ann's Hospital, 419 6th Street--60 beds
11. DILLINGHAM (Population 5,000)
  - a. PHS Alaska Native Health Hospital--38 beds
12. KETCHIKAN (Population 13,800)
  - a. Ketchikan General Hospital, 3100 Tongass Avenue--100 beds
13. KODIAK (Population 9,500)
  - a. Griffin Memorial Hospital, Box 1187--17 beds
  - b. U.S. Naval Hospital--85 beds
  - c. New 25 bed Hospital in construction
14. KOTZEBUE (Population 1,774)
  - a. PHS Alaska Native Health Hospital--54 beds
15. NOME (Population 6,700)
  - a. Maynard MacDougall Memorial Hospital, Box 550--28 beds
16. PALMER (Population 6,400)
  - a. Valley Presbyterian Hospital, Box H--27 beds
17. PETERSBURG (Population 1,800)
  - a. Petersburg General Hospital--21 beds
18. ST. GEORGE ISLAND (Population 250)
  - a. PHS St. George Island Hospital--6 beds
19. ST. PAUL ISLAND (Population 433)
  - a. PHS St. Paul Island Hospital--8 beds
20. SEWARD (Population 2,200)
  - a. Seward General Hospital, Box 365--33 beds
  - b. Wesleyan Hospital, Box 456--22 beds (nursing home)
21. SITKA (Population 8,200)
  - a. Alaska Pioneers Home, Box 198--279 beds
  - b. PHS Alaska Native Health Hospital, Mt. Edgecumbe--166 beds
  - c. Sitka Community Hospital, Box 500--25 beds
22. TANANA (Population 683)
  - a. PHS Alaska Native Health Hospital--32 beds
23. VALDEZ (Population 2,400)
  - a. Valdez Memorial Hospital--165 beds
  1. 150 Ambulatory Mentally Retarded
  2. 15 General Hospital beds
24. WRANGELL (Population 2,000)
  - a. Bishop Rowe General Hospital, Box 80--15 beds
25. SKAGWAY (Population 650)
  - a. The White Pass-Yukon Hospital--12 beds



## LOCATION OF ALASKA'S PACKAGED DISASTER HOSPITALS

### ANCHORAGE

1. Two packaged disaster hospitals are stored at the Alaska Disaster Office Warehouse; Mr. Clyde Blocker, Custodian; Dr. David Duncan, Alternate Custodian.

### FAIRBANKS

1. A packaged disaster hospital is stored at the University of Alaska; Mr. Leonard Lobban, Civil Defense Director, Custodian.
2. A packaged disaster hospital is stored at Fort Wainwright; Mr. Leonard Lobban, Civil Defense Director, Custodian; Dr. Raymond Evans and Mr. Al George, Alternate Custodian.

### HOMER

1. A packaged disaster hospital is stored at the Homer Electric warehouse; Mr. Howard Stone, City Manager, Custodian.

### JUNEAU

1. A packaged disaster hospital is stored in the Fifth Street School, one block from St. Ann's Hospital; Mr. Art Walther, Civil Defense Director, Custodian.

### KENAI

1. A packaged disaster hospital is stored at the Kenai City Warehouse; Mr. Mack McGahan, Custodian,

### KETCHIKAN

1. A packaged disaster hospital is stored in the old Ketchikan Hospital in downtown Ketchikan; Mr. Gordon Zerbetz, Custodian; Dr. J. H. Wilson, Alternate Custodian.

### SEWARD

1. A packaged disaster hospital is stored in the Seward Civil Defense Warehouse; Mr. Kester Gotts, City Manager, Custodian.

### SITKA

1. A packaged disaster hospital is stored at Sitka High School; Mr. Walter Dangel, Civil Defense Director, Custodian.

### NOME

1. A packaged disaster hospital is stored in the FAA Hangar and City Powerhouse; Mr. Howard Crinklaw, City Manager, is Custodian.



# REGIONAL POPULATION

ALASKA 1967

NORTHWEST  
13,000

INTERIOR  
51,000

SOUTHWEST  
28,000

SOUTHCENTRAL  
136,500

ALASKA'S POPULATION

SOUTHEASTERN  
42,800

SOURCE: George W. Rogers, Ph.D., Research Professor of Economics  
Institute of Social Economics and Governmental Research,  
University of Alaska, College, Alaska 99701, from "Economic  
and Social Guidelines for the Washington-Alaska Regional  
Medical Program", July 24, 1967.

Total Population - 272,000  
Military - 31,000  
Civilian - 241,000  
Non-Native - 190,300  
Native - 50,700

## REGIONAL POPULATION

I. Southeastern	- 42,800	IV. Interior	- 51,100
Military	- 700	Military	- 10,600
Civilian	- 42,100	Civilian	- 40,500
Non-Native	- 32,200	Non-Native	- 35,300
Native	- 9,900	Native	- 5,200
II. Southcentral	- 136,500	V. Northwest	- 13,000
Military	- 17,200	Military	- 700
Civilian	- 119,300	Civilian	- 12,300
Non-Native	- 112,000	Non-Native	- 1,800
Native	- 7,300	Native	- 10,500
III. Southwest	- 28,000		
Military	- 4,100		
Civilian	- 23,900		
Non-Native	- 6,100		
Native	- 17,800		

# PROJECTED REGIONAL POPULATION ALASKA 1970-2000



SOURCE: George W. Rogers, Ph.D., Research Professor of Economics  
Institute of Social Economics and Governmental Research,  
University of Alaska, College, Alaska 99701, from "Economic  
and Social Guidelines for the Washington-Alaska Regional  
Medical Program", July 24, 1967.

	Low Estimates	High Estimates		Low Estimates	High Estimates
Anticipated Total Population:			III. Anticipated Southwestern Population:		
1970	293,000	332,500	1970	25,000	26,500
1975	311,000	406,000	1975	26,000	28,000
1980	329,000	491,000	1980	27,000	31,000
1985	349,000	562,000	1985	28,000	36,000
1990	369,000	649,000	1990	29,500	40,000
1995	390,000	808,000	1995	31,000	53,000
2000	411,000	928,000	2000	32,500	73,000
I. Anticipated Southeastern Population:			IV. Anticipated Interior Population:		
1970	44,500	55,000	1970	53,000	75,000
1975	47,000	81,000	1975	56,000	103,000
1980	49,000	112,000	1980	59,000	133,000
1985	51,500	127,000	1985	62,000	138,000
1990	54,500	152,000	1990	65,000	164,000
1995	57,000	213,000	1995	68,000	200,000
2000	60,000	246,000	2000	71,500	232,000
II. Anticipated Southcentral Population:			V. Anticipated Northwest Population:		
1970	156,500	157,000	1970	13,500	19,000
1975	168,000	170,000	1975	14,000	24,000
1980	179,000	184,000	1980	15,000	31,000
1985	191,500	219,000	1985	16,000	42,000
1990	203,000	242,000	1990	17,000	51,000
1995	216,000	275,000	1995	18,000	67,000
2000	228,000	295,000	2000	19,000	82,000



# MUKTUK MORSELS

PEKING: We have a subscription request from China for Alaska Medicine starting with the June issue (see also Book Review section).

NOME: Dr. Joseph O. Rude took care of Nome medical problems during the recent three week vacation of Dr. Harold Bartko. Dr. Carroll H. Long is now working in the Holston Hospital, Yadgire, Mysore State, India.

FAIRBANKS: The Fairbanks Medical Society is still trying to find an anesthesiologist for St. Joseph's Hospital. Two new board eligible internists have joined the Fairbanks Medical and Surgical Clinic, Dr. Gary L. Walkup of Washington State and Dr. Glen W. Straatsma from Michigan. Dr. Walkup's training included a two year residency in radiology while Dr. Straatsma has a year of specialty study in oncology and hematology. Dr. Edward Meyer is continuing his psychiatric residency in Albany, N.Y., after a year in Salt Lake City. He expects to return to Fairbanks after completion of his training. Dr. Paul Stuck is now associated with the Daniel Boone Clinic in Harlan, Kentucky. Dr. Robert Taylor has been stationed in Vietnam by the Navy.

We understand that Mr. Johnson (the plaintiff in the Johnson-Tatum case discussed in the March issue of Alaska Medicine) died on admission to St. Joseph's Hospital several weeks ago.

The Alaska Heart Association is again paying the expenses of the Mayo Cardiac Team on its Alaskan tour, in cooperation with the Alaska State Department of Health and the U.S. Public Health Service. The clinic this year will start in Fairbanks on September 18 and 19, then to Anchorage September 20 and 21 and on to Mt. Edgecumbe September 22 and 23. This should give Fairbanks a fresher

group of cardiologists to work with than they had last year at the tail end of the tour.

GLENNALLEN: Dr. James S. Pinneo writes that he will be outside for one year (12 South Sacramento Ave., Ventnor, N.J.).

ANCHORAGE: Dr. William Mills has safely completed his one year in Vietnam with the Navy at DaNang. Dr. Alan Homa has resumed his practice after a two month tour in a rural Vietnam Hospital with the AMA-AID program. Dr. Richard Paul has left the Anchorage Pediatric Group to go into teaching and private practice with a group in Pittsburgh. Dr. Richard Peterson who is joining the Anchorage Pediatric Group had his first daughter, third child. Dr. Frank Nicholas married Susan Richardson from Virginia in May. Dr. Paul Scholtens has gone to Ann Arbor to be on the radiology staff there. Dr. Donald Rogers passed his Boards in Anatomical and Clinical Pathology in May. Dr. George Hale got his private pilot's license. Dr. Charles St. John got his instrument rating.

Mrs. Gladys (Petee) Stiver, executive secretary of the Alaska Heart Association, died suddenly August 10. The Alaska Heart Association will be getting a career executive from the American Heart Association to take over the office and expand its Alaskan program.

In the week preceeding the local NAACP meeting on Friday, August 11, Anchorage was plagued by rumors of possible violence. The plausibility of these rumors was based on allegations of "outside agitators" who had or were to arrive in town. With Detroit fresh in all minds and despite a basically harmonious race situation in Alaska, the town prepared for the possibility of a riot. It was readily apparent that the number of firearms in responsible Alaskan hands, in both the

public and private sector, were adequate to deal with a full scale invasion. On the evening in question traffic was light and most people stayed at home or in their place of business prepared for any eventuality. Nothing happened. The NAACP meeting was quiet and friendly.

The origin of all these rumors is by no means clear. Whether they were spontaneous or were started to bring attention to race problems, or whether they were actually based on fact has not been determined.

One thing however is certain. Regional and hospital disaster plans were not only updated and distributed but read and ready.

SOLDOTNA: Dr. Elmer Gaede recently sustained compression fractures of L1 and L2 as well as face and neck injuries when he made a forced landing following a sudden engine failure. He expects to be back at work in several weeks. Two passengers sustained similar injuries. As yet no cause for the engine failure has been determined. The Peninsula General Hospital completion has been delayed by financial problems. Dr. Peter O. Hansen, formerly of Juneau, plans to open a Soldotna office in general practice in association with Dr. Paul Isaak and Dr. Elmer Gaede.

KODIAK: Dr. John Eufemio has returned to Kodiak to resume his general surgery practice.

VALDEZ: Dr. Ivan L. Frye of Galveston, Texas, will take over as temporary director of the Harborview Hospital while Dr. John E. Carr is on a 30-day vacation.

CORDOVA: Disaster struck the Packaged Disaster Hospital in Cordova recently when the city warehouse in which it was stored burned to the ground.

SKAGWAY: Dr. Elsa Lehman has opened offices in general practice here.

JUNEAU: With the death of Dr. Jack Gibson and the closing of the Juneau Clinic there has been a marked change in the medical scene here. In addition to the Soldotna move of Dr. Peter Hansen, Dr. Robert Smalley has moved his general surgery offices into St. Ann's Hospital. This leaves Drs. Akiyama, Dalton, Ray, and Reiderer as the only other established physicians in town. Dr. Stan Ray is presently outside and his practice is being covered by Dr. John Reiswig. Dr. Jean Chapman, wife of Commissioner Chapman, is opening an office in general practice.

Mr. Daniels McLean, Deputy Commissioner of Health and Welfare has resigned. Dr. Thomas R. McGowan, Director of the Division of Public Health has resigned. His replacement, Dr. Robert F. Cavitt, of Kansas, is also opening a private office in Juneau for the part-time practice of general surgery. Dr. Harrison Leer has returned to Juneau to practice ophthalmology after several years absence.

Commissioner of Health and Welfare, Dr. Wallace Chapman, has announced termination of the Alaskan contract with Morningside Hospital, Portland, Oregon, for the care of mentally retarded, psychiatric, and geriatric patients. This contract which has been in effect since 1904 is no longer necessary due to "the construction of new facilities, and the development of community programs and resources" which can now provide "equal or superior" care to outside institutions. Facilities mentioned in the news release included the new Harborview Hospital in Valdez, the Sitka and Fairbanks Pioneer Homes, the Alaska Psychiatric Institute, the Jesse Lee Home and various nursing homes.

Mr. George Grimes of Anchorage, past president of the Anchorage Chapter of the American Cancer Society and Dr. Henry Akiyama of Juneau have been nominated to the Alaska-Washington Regional Medical Program Advisory Committee to replace Dr. Wallace Chapman and Mr. James Lanham who re-



signed. Commissioner Chapman was too busy and Mr. Lanham was transferred to another state. Dr. Henry Akiyama has spearheaded an excellent and extensive postgraduate physician education program application which was passed by the Alaska-Washington Regional Advisory committee. If funding is granted, physicians in Southeastern Alaska will have financial assistance for more frequent consultant visits, EKG transmission equipment, video lectures and for travel and locum tenens help for postgraduate medical education trips both inside and outside of Alaska.

While on the subject of postgraduate medical education it should be noted that Mr. Robert Neth of Kansas will be surveying Alaska Sept. 18-30 to determine for the Alaska-Washington Regional Medical Program what the educational needs and wishes of practicing Alaskan Physicians are. More on this later from the Medical Society office.

SITKA: Dr. T. M. Moore has announced his plans to leave his general surgery practice and enter an orthopedic residency in Los Angeles. He hopes to return to Sitka to practice following completion of his orthopedic training.

The Sitka meeting of the Alaska State Medical Association was well run and well attended. Particularly impressive to this Sitka visitor was the Totem park. One could easily imagine, on walking under the tall straight spruce, why this was a favorite walk for Lord Baranof one hundred and sixty years ago. Indeed several eagles and ravens provided considerable and unsubsidized atmosphere, as well as giving one quite a start, when they suddenly screamed or croaked from behind these impressive carvings. In such a dark and peaceful setting totem poles are not an anachronism.



# HIGHLIGHTS:

## Twenty-Second Annual Convention

June 7, 8, 9, and 10, 1967  
Sitka Centennial Building  
Sitka, Alaska

The twenty-second annual convention of the Alaska State Medical Association is now history. With the Alaska centennial celebration and Sitka's historical connections with our centennial, a large number of out-of-state physicians were attracted to this year's meeting.

As usual, a high point of the 1967 meeting was presentation of the physician-of-the-year and the community service awards. Doctor Paul G. Isaak of Soldotna was honored as the physician-of-the-year for his pioneering medicine on the Kenai Peninsula and for his work and perseverance in establishment of the Central Peninsula Hospital, the first hospital in Alaska's most widely growing area.



*Dr. Paul G. Isaak*

Doctor Arthur Wilson, Sr., of Ketchikan received the Association's 1967 community service award for his years of service to the community of Ketchikan.



*Dr. Arthur Wilson, Sr.*

The scientific programs were well attended and we were again fortunate to have outstanding speakers.

### FIRST SESSION OF THE HOUSE OF DELEGATES - JUNE 7, 1967

The House of Delegates of the Alaska State Medical Association convened at 10:00 A.M. on Wednesday, June 7th, in the beautiful Sitka Centennial Building, Sitka, Alaska. Doctor



Robert H. Shuler, President of the Alaska State Medical Association, presided.

The invocation was pronounced by the Reverend Lee W. Stratmen of Sitka.

President Shuler welcomed the delegates to the twenty-second annual meeting and introduced special guests of the Association-- Doctor F.J.L. Blasingame, Executive Vice-President, American Medical Association and Mr. W. David Coyner, A MA Field Representative for Alaska. Doctor Shuler also expressed special thanks to those who contributed time, energy and equipment in the convention formulation.

Doctor Shuler presented a special award to Mr. Ed Waight of the Mead Johnson Company. Mr. Waight was awarded the handle of the ax he decapitated in an "ax throwing contest" which took place at the clam chowder picnic

June 6th. The opening address by President Robert H. Shuler, M.D. was entitled "The Dangers of Complacency". Following President Shuler's opening address, he called for introduction of the proposed budget. Doctor Henry Storrs moved, with a second by Doctor R. Holmes Johnson, to accept the proposed budget as presented by the Council of the ASMA. Motion received unanimous approval.

President Shuler then appointed to the Resolutions Committee: Doctor J. Ray Langdon, Chairman; Doctor Arndt von Hippel, Doctor Edward Spencer, Doctor Henry Storrs; and to the Nominating Committee: Doctor George E. Hale, Chairman; Doctor Peter O. Hansen, Doctor R. Holmes Johnson, Doctor Robert B. Wilkins, Doctor Phil H. Moore.

The House of Delegates was recessed at 11:45 A.M.

# ALASKA STATE MEDICAL ASSOCIATION

## Budget

1967 - 1968

Anticipated Income		Anticipated Expenses	
Dues		Dues Liabilities	
Regular members (ASMA only)	\$27,500.00	AMA-ERF Contribution	\$ 1,350.00
Associate members	<u>200.00</u>	Aces, Deuces Dues and Payments	50.00
TOTAL DUES	\$27,700.00	Alaska Medicine (membership subscriptions)	<u>800.00</u>
		TOTAL	\$ 2,200.00
Convention		Operational Expenses	
Exhibits	2,250.00	Salaries: Executive Secretary	13,800.00
Banquet and Registration	500.00	Office Secretary	5,700.00
Grants, Sponsors, etc.	<u>4,200.00</u>	Payroll Taxes (employer)	950.00
TOTAL CONVENTION	7,250.00	Insurance (Workmen's Compensation and Liability)	137.00
		Auditing and Bond	400.00
Interest on Savings	1,100.00	Rent (Association Office)	1,932.00
		Legal Expense	2,500.00
Alaska Medicine Management	6,000.00	Printing and Duplicating	300.00
		Office Supplies	600.00
Miscellaneous		Telephone and Telegraph	800.00
Secretarial and Administrative Services		Postage	300.00
(American Academy of General Practice)		Automobile Expense	1,200.00
(Anchorage Medical Society )		Travel (Executive Secretary to Component Societies)	500.00
(Heart, Stroke and Cancer )	<u>1,200.00</u>	Capital Expense (necessary office equipment)	<u>800.00</u>
TOTAL ESTIMATED INCOME	43,250.00	TOTAL	29,919.00
		Delegate, ASMA Officers, and Committee Expense	
Cash Balance Forward from Prior Year	<u>2,500.00</u>	Travel, meetings, conferences, publication, reports	4,200.00
TOTAL RESOURCES INCLUDING SAVINGS ACCOUNT INTEREST	\$45,750.00		
		Convention Expense	
		Speakers	5,000.00
		Secretarial services (extra)	300.00
		Printing (Programs, tickets)	400.00
		Banquets and entertainment	1,000.00
		Miscellaneous (Awards, rentals, etc.)	<u>1,000.00</u>
		TOTAL	<u>7,700.00</u>
		TOTAL ESTIMATED EXPENSES	44,019.00
		Reserves for Contingency Fund and Capital Expenses	<u>1,731.00</u>
		TOTAL	\$45,750.00

## SECOND SESSION OF THE HOUSE OF DELEGATES - JUNE 9, 1967

The House of Delegates reconvened at 2:00 P.M. Friday, June 9th. Committee reports were called for and Doctor George Hale, gave a report on the Tumor Registry Committee's actions during the year 1966-67.

Doctor Shuler briefly discussed the Veteran's Administration fee schedule, then introduced Doctor Richard Kraft, Regional Director of the Veteran's Administration. Doctor Kraft addressed the House of Delegates, reporting that the Veteran's Administration had recently accepted the suggested fee schedule of the Alaska State Medical Association and that a contract to that effect would soon be issued. The Veteran's Administration's fee schedule will be based on the California Relative Value Study with unit values of medicine, \$ 8.00; x-ray, \$ 7.50; laboratory, \$ 7.50; and surgery, \$ 8.00.

Doctor H. I. Akiyama, President, Alaska Board of Medical Examiners, reported on a meeting of the Board of Medical Examiners and stated that a formal report would be forthcoming upon completion of some needed research. Members of the Board of Medical Examiners now include: H. I. Akiyama, M.D., President, 1420 Glacier Avenue, Juneau, Alaska; James A. Wilson, M.D., Secretary-Treasurer, Box 2577, Ketchikan, Alaska; Charles F. St. John, 207 East Northern Lights Blvd., Anchorage, Alaska; Harold Bartko, M.D., Box 550, Nome, Alaska; and Raymond D. Evans, M.D., Box 1330, Fairbanks, Alaska.

Doctor Shuler reviewed the bills which were passed by the Alaska State Legislature pertaining to the medical profession. Senate bills which passed and were signed into law are as follows:

Senate Bill 40 - relating to nursing, Chapter 47, Alaska Statutes

Senate Bill 53 - relating to licensure of psychologists, Chapter 136, Alaska Statutes

Senate Bill 89 - relating to good Samaritan acts, Chapter 32, Alaska Statutes

Senate Bill 98 - relating to veterinarians, Chapter 54, Alaska Statutes

Senate Bill 142 - relating to burden of proof in malpractice actions, Chapter 49, Alaska Statutes

The only Senate resolution pertaining to medicine which passed the legislature was Senate Joint Resolution #2, relating to the establishment of hospitals at St. Mary's, Andreafsky, and Unalakleet. House bills which were enacted into law are as follows:

House Bill 73 - nature of test to discover PKU, Chapter 39, Alaska Statutes

House Bill 201 - licensing of child placement and counselling agencies, Chapter 77, Alaska Statutes

House Bill 270 - comprehensive health advisory council, Chapter 122, Alaska Statutes

House Bill 276 - charging fee for premarital laboratory tests, Chapter 124, Alaska Statutes

House Bill 324 - immunization of school children with certain exceptions, Chapter 131, Alaska Statutes

House Bill 329 - alcoholism advisory board, Chapter 132, Alaska Statutes

Two House resolutions were approved. They are as follows:

House Joint Resolution 4 - funding of the Bethel Premarital Home

House Resolution 6 - boundaries of responsibility of private and governmental agencies in the practice of medicine and dentistry.

Doctor Robert H. Shuler then introduced Doctor J. Ray Langdon, Chairman of the Resolutions Committee, and asked him to present resolutions to the House of Delegates.



The following fifteen resolutions were adopted by the House of Delegates;

RESOLUTION 67-1  
THE STANDARD FEE SCHEDULE

WHEREAS the State and Federal Governments are expanding their fields of medical coverage, and

WHEREAS in some instances, such as Federal Government Medicare, they pay the average fee

NOW THEREFORE BE IT RESOLVED again to ask these various government agencies to accept the standard fee schedule for medical services, as a basis for negotiation and to renegotiate as indicated by cost changes from time to time.

(Submitted by: Fairbanks Medical Society - passed by FMS May 11, 1967)

RESOLUTION 67-2

RAISE IN CONVERSION FACTORS FOR  
FEE SCHEDULE

WHEREAS there has been a steady increase in cost of living, and

WHEREAS there are more third parties and insurance companies referring to our relative value fee schedule, and

WHEREAS this fee schedule was adopted in 1964 - three years ago

NOW THEREFORE BE IT RESOLVED that the conversion factor for the state of Alaska be raised by 0.5 to correlate with the increase so that medicine will be \$8.50, surgery will be \$ 8.50, laboratory will be \$ 8.00, and x-ray will be \$ 8.00.

(Submitted by: Fairbanks Medical Society - passed by FMS May 11, 1967)

RESOLUTION 67-3

NOMINAL FEE FOR ADDITIONAL REPORTS

WHEREAS there is an ever increasing

amount of paper work involved in the practice of medicine, and

WHEREAS this paper work is the nemesis of the physician, and

WHEREAS the Insurance Company or other third party can increase, compound and expand this paperwork by requesting additional information

NOW THEREFORE BE IT RESOLVED THAT, beyond the initial standard report form, the ASMA endorses the principle that the insurance company and all government agencies pay a nominal fee for such additional information as determined by the individual M.D.

(Submitted by: Fairbanks Medical Society - passed by FMS May 11, 1967)

RESOLUTION 67-4

SPECIAL COMMITTEE  
TO IMPLEMENT HR #6

WHEREAS the Fifth Legislature, first session passed a resolution requesting assistance of the ASMA, and

WHEREAS this resolutions titled House Resolution #6 requests clarification of the boundaries between private and governmental responsibilities in the practice of medicine for the improved health of all Alaska Citizens, and

WHEREAS this resolution requests the ASMA to submit a report of their findings within ten (10) days after the convening of the annual session of the Fifth State Legislature,

THEREFORE BE IT RESOLVED that the ASMA create a committee to be appointed by the President to fulfill the requests of HR #6 and that the information be submitted to the Council prior to the convening of the second session of the Fifth State Legislature.

(Submitted by: Robert H. Shuler, M.D., President, ASMA)

RESOLUTION 67-5

OVERLAPPING OF PUBLIC AND PRIVATE  
LABORATORY SERVICES

Substituted for resolution #6, submitted  
by Dr. Beirne

WHEREAS various laboratory procedures have at times been discussed as overlapping private and public laboratory services.

BE IT THEREFORE RESOLVED that consideration of laboratory services be considered as a major item for special committee on HR #6.

RESOLUTION 67-6

ASMA'S COOPERATION AND SUPPORT  
IN CONTROLLING CIGARETTE SMOKING

WHEREAS the public health is properly the concern of organized medicine and

WHEREAS the prevention of disease is the duty of every physician and

WHEREAS cigarette smoking has been clearly related to a remarkable increase in many diseases and

WHEREAS the indiscriminate advertising of cigarettes appears particularly effective on the young, where it is also potentially the greatest health hazard,

THEREFORE NOW BE IT RESOLVED that the Alaska State Medical Association give its full cooperation and support to public health and educational measures designed to control this major health hazard.

(Submitted by: Arndt von Hippel, M.D.)

RESOLUTION 67-7

LIAISON COMMITTEE WITH THE  
ALASKA STATE NURSES ASSOCIATION

WHEREAS the Alaska State Nurses

Association has requested better communication between the Alaska State Medical Association and the Alaska State Nurses Association, and

WHEREAS communication between these associations would be of benefit to both public health and the associations,

THEREFORE BE IT RESOLVED that a Liaison Committee be appointed by the 1967-68 ASMA President to meet with a similar committee from the Nurses Association to form a communication link.

(Submitted by: Robert H. Shuler, M. D., President, ASMA)

RESOLUTION 67-8

REMINDER OF ETHICS ON ADVERTISING

WHEREAS advertising by physicians is unethical and not in the best interests of the patient, and

WHEREAS this has long been a basic ethic of the medical profession

NOW BE IT RESOLVED that the ASMA remind its members that such advertising will be considered an unethical practice.

(Committee substitute for resolution by Doctor Lundquist)

RESOLUTION 67-9

USPHS CONTRACTING WITH ALL  
ASMA MEMBERS

WHEREAS the ANH is now contracting for medical services on a fee for service basis, and

WHEREAS all citizens of this state regardless of racial origin should be entitled to free choice of physician without financial pressure, and

WHEREAS physicians in private practice are capable, able, and willing to offer their services, according to their training and licensure by State law, to all citizens who seek their services,



NOW THEREFORE BE IT RESOLVED that the ASMA urge the ANH to make use of all members of the ASMA for health services rather than contracting with a few, and

BE IT FURTHER RESOLVED that this problem be considered by the special committee on HR #6.

(Submitted by: Henry G. Storrs, M.D.)

#### RESOLUTION 67-10

##### RECOMMENDATION THAT THE USPHS TIGHTEN ITS ADMISSION POLICIES

WHEREAS USPHS Hospitals have been established to care for indigent Alaska Natives as well as other established beneficiaries of USPHS, and

WHEREAS these institutions have usually been extremely lax in screening admissions to the point that little determination is made of ability to pay or beneficiary status

WHEREAS this creates a state of dependency of the Native population on the USPHS Hospital at a time when the economy of Alaska is expanding and the employment potential for natives is growing, and the Native is moving toward the point of First class citizenship, which includes his being responsible for his own debts when he is able

NOW THEREFORE BE IT RESOLVED that ASMA strongly recommend to USPHS that its admission policies be tightened as part of an overall effort to encourage Alaskan Natives to become self-sufficient in attitude as well as in fact.

(Submitted by: R. Holmes Johnson, M.D.)

#### RESOLUTION 67-11

##### APPRECIATION AND APPROVAL OF THE ALASKA-WASHINGTON REGIONAL MEDICAL PROGRAM

WHEREAS ASMA Past President Royce Morgan, former Commissioner of Health and Welfare Levi Browning, and former Governor

William Egan requested that Alaska be included as part of a region under the Heart-Cancer-Stroke legislation, and

WHEREAS Dr. Bruce Wright, as the appointed representative of ASMA, has served on the Regional Advisory Committee and is chairman of the Alaska Co-ordinating Committee for the Regional Medical Program with other Alaskan representatives appointed by the Governor, and

WHEREAS the University of Washington, as the applicant under the Regional Medical Program, and all the Advisory Committee members have shown the greatest interest in this opportunity for working co-operatively with Alaska in meeting the goals of the program, and

WHEREAS planning under the Regional Heart-Cancer-Stroke Program has proceeded satisfactorily, and three requested programs for Alaska have been approved and should be implemented in the near future,

THEREFORE BE IT RESOLVED that the ASMA approve the existing Alaska-Washington arrangement for implementation of the Heart-Cancer-Stroke Program in Alaska, and extend its thanks and congratulations to the Alaska Co-ordinating Committee and the entire Alaska-Washington Advisory Committee for their time and most valuable efforts.

(Submitted by: Robert B. Wilkins, M.D.)

#### RESOLUTION 67-12

##### HONORARY MEMBERSHIP

WHEREAS all of the guest speakers at the ASMA convention currently in session have proved to be of the highest quality and to have contributed immeasurably to the success of the convention and the edification of Alaskan physicians,

THEREFORE BE IT RESOLVED that the ASMA extend Honorary Membership to all of the guest speakers.

(Submitted by: Robert B. Wilkins, M.D.)

# PICTORIAL PROCEEDINGS



*Phil Chase, Giegy  
Casper the friendly ghost!*



*Joe Huhn,  
Burroughs Welcome  
W.P.A.?*



*Nome, Alaska--St. Petersburg, Florida  
Harold Bartko, M.D.--Grover Austin, M.D.*



*Look Mom--No oars and no motor.*



*Dr. Bob Shuler--Past Pres.--4 A.M.--the fishing was  
lousy but the clam digging was superb.*



*Dr. Bob Wilkins, President  
The time has come, the  
walrus says, to speak of  
many things.*



*C. Wesley Eisle, M.D.--  
Assoc. Dean Postgraduate  
Medical Education, U. of  
Colorado--and A.S.M.A.'s  
Clam Digging Daddy.*



RESOLUTION 67-13

APPRECIATION TO MRS. ALMA BURCH

WHEREAS Mrs. Alma Burch has been the Office Secretary of ASMA for the past year and one half, and

WHEREAS Mrs. Burch is anticipating leaving employment with the Association, and

WHEREAS Mrs. Burch has rendered very fine service to the Association during her term of employment,

THEREFORE BE IT RESOLVED that the ASMA express its thanks and appreciation to Mrs. Burch for this outstanding service. (Submitted by: Robert G. Ogden, Executive Secretary)

RESOLUTION 67-14

AMA DELEGATE

WHEREAS the ASMA enjoys the privilege of sending representatives to State and National medical organizations, and

WHEREAS these representatives in addition to using good judgment, are expected to reflect the thinking of the Society, and

WHEREAS the thinking of the Society is best and properly expressed at the annual meeting of the ASMA, or on special counsel with the membership

NOW THEREFORE BE IT RESOLVED that the representative and his alternate be urged to attend the annual meeting of the ASMA, to poll the members on important issues, and to report on his impressions and activities as delegate following each AMA meeting.

(Submitted by: Henry G. Storrs, M.D. and Arndt von Hippel, M.D.)

RESOLUTION 67-15

PATIENT'S FREE CHOICE OF PHYSICIAN

WHEREAS any infringement on the free choice by the individual of his physician at

the time he becomes ill or injured is an infringement on the free practice of medicine as we now enjoy it,

NOW THEREFORE BE IT RESOLVED that the physicians of this association will abstain from participating in any such contractual relation that prohibits the free choice of physician.

(Submitted by: Henry G. Storrs, M.D., May 1967)

President Shuler then called for a report from the Nominating Committee. It was moved by Doctor George Hale, Chairman of the Nominating Committee, that the nominations, as recommended by the Committee, be placed on the floor for action by the House of Delegates. Motion seconded and carried. Doctor Shuler asked if there were further nominations; there were none. Doctor Robert B. Wilkins moved to accept unanimously all nominations on the ballot except the Anchorage councilors, since there were two members running for one position (J. Ray Langdon, M.D. and Peter Koeniger, M.D.) Motion seconded and carried. Secret ballot voting on the Anchorage Councilor followed with Doctor J. Ray Langdon being chosen as the councilor from Anchorage. The officers, delegates, and councilors for the coming year, 1967-68, are as follows:

President, Robert B. Wilkins, M.D.

President-Elect, James A. Lundquist, M.D.

Vice-President, Peter O. Hansen, M.D.

Past-President, Robert H. Shuler, M.D.

Secretary-Treasurer,

Alistair C. Chalmers, M.D.

AMA Delegate, Joseph M. Ribar, M.D.

Alternate Delegate, Royce H. Morgan M.D.

Anchorage Councilor, J. Ray Langdon, M.D.

Southcentral Councilor, Paul G. Isaak, M.D.

Southeastern Councilor,

Edward D. Spencer, M.D.

Doctor Robert B. Wilkins, newly elected president, asked for consideration by the



*Robert B. Wilkins, M.D.  
President*



*James A. Lundquist, M.D.  
President-Elect*



*Peter O. Hansen, M.D.  
Vice President*



*Alistair C. Chalmers, M.D.  
Secretary-Treasurer*



*Robert H. Shuler, M.D.  
Past President*



*Joseph M. Ribar, M.D.  
AMA Delegate*



*Royce H. Morgan, M.D.  
Alternate Delegate*



*Nicholas Deely, M.D.  
Northern Councilor*



*J. Ray Langdon, M.D.  
Anchorage Councilor*



*Edward D. Spencer, M.D.  
Southeastern Councilor*



*Paul G. Isaak, M.D.  
Southcentral Councilor*



House of Delegates of dates for the 1968 annual meeting. After discussion, it was moved by Doctor James Lundquist that the meeting dates for the next year begin on June 5th. Motion was seconded by Doctor Storrs and carried. Upon asking for any other business, and hearing none, the 1967 meeting of the House of Delegates was adjourned at 4:00 P.M. Friday, June 9, 1967.

SPECIAL SESSION OF THE  
HOUSE OF DELEGATES  
SATURDAY, JUNE 10, 1967

The special session of the ASMA House of Delegates was called to order by the newly elected president, Doctor Robert B. Wilkins. The meeting was called for the purpose of reconsideration of Resolution #2. Doctor Robert Shuler, Past-President, moved that the resolution be brought to the floor for reconsideration. Motion was seconded by Doctor T. M. Moore and discussion followed. After considerable discussion, President Wilkins asked for a vote on the motion. Voting followed with a negative vote on the reconsideration. Doctor T. M. Moore of Sitka then moved that the officers of the Alaska State Medical Association be instructed to sign the proffered contract by the Veteran's Administration. Motion seconded and passed unanimously. Doctor Robert H. Shuler, Past President, submitted a new resolution and requested approval to allow presentation. Doctor Shuler's resolution was read and unanimous approval was granted to allow it to be brought to the floor for action. The resolution was pertaining to usual and customary fees. Doctor Henry Storrs of Fairbanks moved that the resolution be approved by the House of Delegates. Motion was seconded by Doctor Holmes Johnson and carried. Resolution number 16 is as follows.

RESOLUTION 67-16  
USUAL AND CUSTOMARY FEES

WHEREAS the usual and customary fee method of billing for medical services has been considered to be fundamentally the best method for both the physicians and the patient, and

WHEREAS the Commissioner of Health and Welfare of the State of Alaska has at this meeting announced the intention of his agency to institute in the near future a system allowing for the usual and customary fee method of billing for services rendered by physicians,

THEREFORE BE IT RESOLVED that the Alaska State Medical Association endorse the usual and customary fee method of billing as the method preferred in all instances

AND BE IT FURTHER RESOLVED that the Alaska State Medical Association urge every agency utilizing the services of physicians in Alaska to follow the example of the Alaska Department of Health and Welfare and to sanction billing of the usual and customary fee so that the fee schedule concept can be abandoned altogether.

(Submitted by: Robert H. Shuler, M.D.)

Doctor Henry Storrs, Fairbanks, introduced the subject of membership dues, stating that the dues have risen to the pinching point and mentioned that the office of ASMA should do services for the Anchorage Medical Society and the Alaska Dental Society. This matter was discussed by the Executive Secretary, Mr. Robert Ogden, stating that the office of ASMA is providing administrative and secretarial services for the Anchorage Medical Society, the Alaska Academy of General Practice, the Regional Medical Program, and Alaska Medicine. Upon asking for any other business, and hearing none, Doctor Wilkins adjourned the special session of the House of Delegates at 1:00 P.M.

# LUNG SCANNING

By Bruce C. Wright, M.D.

A newly developed radio-isotope scanning procedure employs aggregates of human serum albumin onto which are tagged Iodine 131. When this material is injected in the antecubital vein in the recumbent position mechanical filtration of the aggregates of albumin occurs within minutes. Since the particle size varies from 5 to 25 microns, about 90% of these aggregates are held in the arterioles of the lungs. This indeed represents a deliberate showering of the lungs with radio-activity tagged emboli; however, it should be pointed out that only 1 to 10,000 arterioles are blocked by this procedure and that in the 4 years of active use, no untoward effects from pulmonary embolization have been noted. During the time that these large aggregated particles are trapped within the lung, a simple scanning procedure with relatively good definition can demonstrate the blood flow pattern to both lungs.

The albumin particles are well tolerated and possess no antigenic properties. Urticaria has been reported, and a questionable case of angioneurotic edema. The paucity of side effects makes this an extremely safe procedure. After several hours, the aggregated albumin particles are resorbed from the lung tissue and the iodine and waste products are cleared by the kidneys. Scandoses run from 150 to 300 microcuries of I<sup>131</sup>.

While the primary purpose of lung scanning is for the safe and early detection of pulmonary embolism as well as to determine the site and extent of reduced perfusion, other possible uses are: evaluation of the degree of focal lack of perfusion in pulmonary emphysema, pneumonitis and lung tumors; detection of ischemic and poorly functioning lung tissue particularly in unilateral lung disease; and estimation of regional perfusion in chronic

pulmonary tuberculosis. It is useful also to evaluate arterial perfusion in abnormally trans-radiant lung fields on x-ray. Some of the various patterns of pulmonary perfusion are shown in the accompanying figures.

Diagnosis of massive pulmonary embolism is commonly difficult and uncertain. Symptoms often mimic other diseases such as pneumonia or myocardial infarction. Episodes of sudden dyspnea, pleural pain, hemoptysis, or syncope, which are transient, are often undecipherable.

The frequency of unsuspected pulmonary embolization at autopsy has been emphasized in recent years. Patients particularly prone to this disease are those in congestive failure or with polycythemia, or those who are bedridden postoperatively or during the postpartum period.

In the past when therapeutic measures for the treatment of pulmonary embolus were non-specific, absolute diagnostic accuracy was not required. However, with the advent of modern anticoagulant drugs and surgical therapy such as ligation or plication of the inferior vena cava, and even pulmonary embolectomy; more accurate diagnostic procedures are required.

While pulmonary arteriography can give immediate positive demonstration of obstruction of the pulmonary circulation, the procedure is time consuming, technically somewhat difficult to perform, and requires injection of large quantities of high density contrast media directly into the pulmonary artery, with the usual risks of cardiac catheterizations. Other examinations such as standard chest films and electrocardiography are rarely definitive.





FIGURE I: This demonstrates an unsuspected pulmonary embolus at the right base in a patient who has recently undergone left sided thoractomy. Chest film demonstrated usual postoperative changes on the left and only vague findings of a small amount of fluid at the right base. The lung scan demonstrates near complete loss of perfusion on the left side, a common postoperative finding and decreased perfusion at the right base. It is noteworthy that the right mid-lung field shows increased perfusion, also a common occurrence after unilateral thoracotomy.

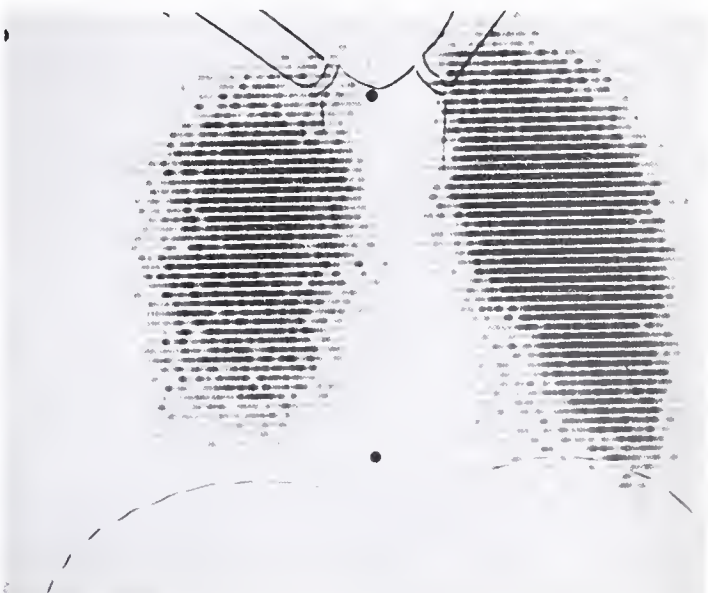


FIGURE II: This demonstrates loss of perfusion at the right base in a patient with known lobar pneumonia. Note how mediastinal structures including heart shadow are well delineated by the scan technique. Chest film clearly shows a heavy opacification in the right lower lobe.



FIGURE III: This is a good example of the findings in pulmonary emphysema and pneumonitis. It is clearly evident from the chest film that heavy density is present in the left upper lobe. Not so apparent from the chest film is a severely decreased perfusion in the right upper lobe secondary to bullous emphysema in that area. The findings on the left actually are changes secondary to infection on top of bullous emphysema.

# REVIEWS OF RECENT BOOKS

As a service to our Chinese readers (see Muktuk) we have asked Dr. J. Ray Langdon of the Langdon Psychiatric Clinic to do a book review on the little red book of Chairman Mao.

QUOTATIONS FROM CHAIRMAN MAO TSE-TUNG, Foreign Language Press Peking 1966 (First Edition)

In reviewing Quotations from Chairman Mao Tse-Tung, one is naturally drawn to comparisons with other Communist writers, from Karl Marx to Lenin and Stalin. In addition, one should consider other political or politico-philosophical authors, such as Plato, Voltaire, Tom Paine, John Adams and Hitler.

One common denominator, despite divergent points of view, is dullness. Though Voltaire and Paine may have struck occasional literary sparks, the reality is that politicians and political philosophers seem not to have been touched by the literary or poetical genius. How then can we explain the impact of such dull, tasteless, repetitious works, which shamelessly paraphrase or plagiarize many other writers from the Bible and Koran to each other?

A possible explanation is that most of these (including Mao's quotes, which range from 1925 to 1964) are written in a state of omnipotent despair, or hopeless omnipotence, whichever fits better. Despite Marx's and Mao's continued statements about the victory of the "proletariat" (whatever that is, as it is poorly defined) it would appear that neither of them, nor their Russian counterparts, ever really expected this to come to pass. This may explain some of the problems both Russian and Chinese Communists have had in putting thought into action once they have unexpectedly come to power. Sam Adams had a similar problem in the American Revolu-

tion, but he did not succeed to power, and the thinkers-in-action, such as John Adams and Thomas Jefferson and Alexander Hamilton, had an opportunity to act. In contrast, Lenin, Stalin, Hitler, and even DeGaulle, who have acted automatically according to predetermined thought, have been unable to come up with new ideas and solutions as conditions change; i.e. their tactics are often fine (and often not) but their strategy is inflexible. This aspect of strategy may be and often is, confused with principle, but the strategy of acquiring and keeping power, which is clearly delineated throughout Mao's work, is not necessarily or even probably equated with the "greatest good to the greatest number."

The word or idea "paranoid" is undoubtedly overworked as it has so often been used to describe those who disagree with another group. However, psychologically or psychiatrically this term denotes an attitude of mind which may exist even if some of the facts support the ideation. In other words, a delusion may still be a delusion even though some of the ideas may be in accord with facts. Unfortunately the tendency of most of us, and even more so with the paranoid is to exalt the ideas, even facts, which agree with us and to denigrate or even ignore or deny those which disagree with those we hold dear. Having denied these it is important to keep them denied by violent words ("running dogs of the capitalists") or violent actions such as assault, murder, or insurrection. All these are in many cases covertly and often even overtly counselled in Mao's deadly dull prose.

As this book is a collection of short quotes from many other works, from articles to books, it is conceivable that some of the ideas may be better developed than appears in this work. However, there are many contradictory terms which recur in several quotes over many years, so it is probable



that this book is truly representative of Mao-think.

It is unfortunate that a work that is so widely at least owned if not read and that apparently has considerable impact is not more literarily contrived, but so be it.

J. Ray Langdon M.D.

MANUAL OF PREOPERATIVE AND POST-OPERATIVE CARE. By the Committee on Pre and Postoperative Care of the American College of Surgeons. Henry T. Randall, M.D., Chairman of the Editorial Subcommittee. 506 pages. Philadelphia, Penn.: W. B. Saunders Company, Publisher, 1967. 506 pages, \$ 8.50.

More than a handbook less than a text, authoritative, concise, and useful, this new Manual of Preoperative and Postoperative Care is an outline of modern methods in the management of surgical problems. It is an outgrowth of the Committee on Pre and Postoperative Care of the American College of Surgeons, which has been conducting courses and preparing associated outlines since 1959. The roster of authors includes many eminent authorities on surgical physiology, headed by Doctors Henry T. Randall, James D. Hardy, and Francis D. Moore, who are the editorial subcommittee. Expressly written for the clinical surgeon, whether tyro house officer or venerable senior partner, the Manual is a "must" book, both for preface-to-appendix reading and for quick reference to the isolated fact. It deserves, and surely will find, wide distribution in operating suites, nursing stations, and surgeons reference shelves around the world, wherever surgeons have responsibility for bringing current knowledge to their management of patients.

The Manual has the virtues and faults of many books that are written by multiple

authors and compiled by committee. Its information is "gospel", for the authors are pre-eminent, and whatever might be thought trivial or controversial has been edited out. Sometimes the paring of content has led to the omission of any discussion of currently widespread practices (such as the use of neomycin and kanamycin in bowel preparation). The chosen format is narrative rather than outline in form and serves well the presentation of so complex a subject. The diagrams are useful and perhaps too few. The style is "American Committee"—varying from didactic to platitudinous, and from slightly turbid to semi-opaque.

It is not kind to find fault with so useful a book. In the interest of conciseness the editors must have made many hard decisions about what material to include and what to omit. In a future edition, however, I should hope to see more detailed and thoughtful discussion of pre-operative evaluation, since the nastiest problems are often those which were unforeseen, and surgeons are not always the best internists. For example, the authors suggest that patients over 50 should have a routine fasting blood sugar test. But there are a number of endocrinologists who think that a two hour postprandial blood sugar after a standard test meal is more sensitive, and therefore a more useful, screening test. Undiscovered latent diabetes which becomes overt under the stress of operation can raise such havoc postoperatively, that the authors' casual approach to such a serious problem seems cavalier. The chapter on preoperative evaluation has a list for evaluation of organ systems, and perhaps in a future edition this could be expanded point by point by some literate internist.

There is no easily found, compact section on the management of the severely injured patient with multiple injuries, and if ever a house officer wants quick reference to an outline of management, this is the time. There

is no discussion of the early, empiric antibiotic therapy of fecal contamination of the peritoneal cavity. Moreover, I should have wished for a clearer emphasis on the insidious dangers of hypoxia in the fat, the aged, and the weak, the hazards of nitrous oxide as an anesthetic agent, and the importance of a "stir-up" regimen during the first postoperative day. One gets the impression that the authors have not recently personally "coughed" a patient nor observed the profound sedative effect of 15 mgm. of morphine sulfate in a single dose. At least one minor error has crept in: flow rate through a needle is proportional not to the square of the diameter but to the fourth power. Lastly, the publishers should know that a reference text is no better than its index and might be advised both to expand this one and to hire a surgeon to revise it.

Professors Randall, Moore, and Hardy, and their contributors all deserve the profound gratitude of the countless surgical patients who will ultimately benefit from their time and energy spent in creating this book, which brings their knowledge in useable form from the surgical physiology laboratory to the clinical surgeons who will use it.

Frederick J. Hillman M.D.

"New Drugs": 1967 edition Evaluated by A.M.A. Council on Drugs, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610, 1967, pp 590, 16 X 24 cm., \$3.50.

The physician must have readily available sources of balanced, authoritative information in order to cope effectively with the complexities of modern pharmacotherapy. New Drugs, a publication of the A.M.A. Council on Drugs, now in its third edition, provides such information on new drugs.

The 1967 edition of "New Drugs" is a com-

pilation of introductory statements on various therapeutic classes of drugs and monographs on single-entity drugs marketed in the United States during the period 1957-1966. It contains 265 individual drug monographs, each of which gives information on the actions and uses of the drug and its adverse reactions, contraindications or precautions, dosages and routes of administration, and sizes and strengths of available preparations. The introductory statements to 21 chapters have been thoroughly revised and 10 new monographs have been added. These monographs and introductory statements are based on a thorough review and evaluation by the Council on Drugs and its consultants of all of the laboratory and clinical information, including unpublished data, available to them. Thus, the book presents a concise, unbiased assessment of the newer drugs within the perspective of the therapeutic application of all of the commonly used agents in a particular class of drugs. Since a monograph on a drug is included whether or not the Council's opinion is favorable, "New Drugs" is in no sense a list of approved or accepted drugs.

The index lists drugs by both their non-proprietary (generic) and trade names and includes therapeutic entries. A list of Canadian trade names equivalents is given in the appendix.

PATHOLOGY, by Stanley L. Robbins, M.D., Department of Pathology, Boston University School of Medicine, W.B. Saunders Company, 3rd Edition 1967, 1434 pages, \$20.50 single volume.

In all fields of medicine there is a continual need for revision of textbooks to present well documented facts and knowledge in a logical and reliable fashion. In this newest and up to date revision of a long accepted textbook of pathology, the author has included



all worthwhile general knowledge in one volume. Excellent illustrations depict the classical tissue changes of many diseases. As a textbook or reference book the new edition will provide a more than adequate up to date source of general information in the field of pathology. It should also serve to clarify current concepts of disease processes, without attempting to make pathologists out of the individuals desiring such knowledge. —

Fred T. Strauss, M.D.

“PATHOLOGIC PHYSIOLOGY” by William A. Sodeman, M.D. and William A. Sodeman Jr., M.D. W. B. Saunders Company, 1051 pages, \$19.00.

The fourth edition of “Pathologic Physiology” by Sodeman and Sodeman, published 1967, is a collaboration by twenty-five distinguished physicians most of whom are in-

ternists. It constitutes a survey of problems pertaining to Internal Medicine as explained by alterations in underlying abnormal physiology. The new edition stresses particularly a study of new concepts in auto-immune disease and genetics. There has been a trend in the new edition to extend the physiologic interpretation to the molecular level. The orientation of the work is toward the medical student and stresses underlying concepts rather than superficial symptoms or treatment. I believe that the book will have its greatest interest as a reference work in studying a particular clinical problem rather than as a recipe for treatment of a particular condition. The contributors are leaders in their field and the book as a whole is well organized and clearly written. It should be a welcome addition to any up to date reference library.

Theodore Shohl, M.D.

## MEDICAL BRIEFS Preventing Sore Feet in Vietnam

CHICAGO--American troops in Vietnam may have a solution to a problem that plagued soldiers in earlier wars: how to keep wet feet from getting sore.

Silicone grease may be the answer, reports a recent (May 22) Journal of the American Medical Association.

When troops spread it liberally on their feet and socks, it was found they could endure wet feet for several days without suffering the painful, disabling condition known as “warm-water-immersion foot.”

The ailment is similar to what soldiers of World War I and II and Korea called “trench foot.” Although the grease seems to help, investigators still aren’t certain what causes the problem.

Pain seems to develop when foot calluses expand and contract on wrinkled, water-soaked skin.

Marines in Vietnam in late 1965 reported a high incidence of warm-water-immersion

foot. Investigators at the University of Miami, sponsored by the Armed Forces Epidemiological Board, were able to duplicate Vietnam water temperatures (70 to 75 degrees F.) in the Florida Everglades.

The silicone-grease applications were developed during these studies. The current JAMA article reports further testing at the Marine training base at Camp Lejeune, N.C., where it was confirmed that the grease would prevent or retard development of sore feet for several days under combat conditions.

It was long believed that temperature loss to cold water sloshing around in a combat boot was a major cause of sore feet. This view may have to be revised, a Journal editorial says.

Authors of the report are Larry J. Buckels, M.D., of the Naval Medical Field Research Laboratory, Camp Lejeune, N.C., and Gustave T. Anderson, M.D., Bureau of Medicine and Surgery, Navy Department, Washington, D.C.

# WMA OPEN TO INDIVIDUAL MEMBERSHIP

Individual membership in the World Medical Association is now open to all members of the American Medical Association. Dues are ten dollars per year. This includes a subscription to World Medical Journal and the privilege of participation in the World Medical Assembly each year.

The 21st World Medical Assembly will be held in Madrid, Spain, Sept. 10 to 17, 1967. The 1968 assembly will be held in Australia.

The World Medical Association is a society for the free, professional medical associations of the free nations. Sixty national medical associations are members, including the AMA.

The 20th World Medical Assembly last winter in Manila created for the first time an individual associate membership within the WMA. Members of the national medical associations may now join WMA as individuals.

Gerald D. Dorman, M.D., of New York city, member of the AMA Board of Trustees, is chairman of the Council, the governing body of the WMA. The WMA Headquarters Secretariat is located at 10 Columbus Circle, New York city. Secretary General is Alberto Z. Romuladez, M.D.

Application for individual membership may be made in the form of a letter to WMA at the New York city office. Applications should be accompanied by a check for ten dollars, with a statement that the applicant is a member in good standing of AMA. The letter should specify whether the applicant wishes to receive the World Medical Journal in English, Spanish, or French language edition. Check should be made payable to The World Medical Association, Incorporated. WMA is a tax-exempt organization. Five-year memberships are available for fifty dollars. Information regarding the 21st World Medical Assembly will be mailed promptly to all applicants for individual memberships.

"The World Medical Association," said Dr. Dorman, "is uniquely qualified to act as a force for peace and understanding in the world today. WMA is a very real and vital part of the world health picture, continually seeking to solve world medical problems through the community spirit and action of its professional membership."

Dr. Dorman made it clear that the WMA has no connection with any government, that it is committed to the philosophy that medical and scientific knowledge should be universally available and free of all political control.

WMA was organized in 1947. In 1965 it was incorporated as a nonprofit educational and scientific organization under the laws of New York state. Funds donated to the organization are tax-deductible.

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# ANNOUNCEMENT

## Brief Report Section Planned

*To assist the busy physician in presenting interesting Alaskan medical cases or problems, ALASKA MEDICINE is starting a BRIEF REPORT section. We hope to limit each case to one page or less including illustrations. This will avoid the extensive "discussion" and "review of the world's literature" portions which are so time consuming to present, tedious to read, and expensive to print. In this way we hope to make space available for material which otherwise would not be reported, and to abbreviate papers which are prolix.*

## MEETING NOTICES

The American College of Chest Physicians Interim Clinical Meeting will be held at the Warwick Hotel, Houston, Texas, November 25-26, 1967.

This program will consist of a two day scientific program with round table discussions and fireside conferences. A highlight of this program will be a panel discussion held at the NASA Manned Spacecraft Center.

Subject: "Cardiorespiratory System and Space Flight". Moderator: Charles A. Berry, M.D., Chief of Center Medical Programs.

Administrative and Committee meetings will be held on Monday, November 27.

This meeting is just prior to the American Medical Association Clinical Meeting November 26-29, 1967.

For a copy of the program and other details please write to the Executive Office of the American College of Chest Physicians, 112 East Chestnut Street, Chicago, Illinois 60611.

# # #

An intensive program on "Current Con-

cepts in Cardiology", with special emphasis on coronary disease, indication and management of valvular replacement, diagnosis and management of cardiac arrhythmias, vector-cardiography and applied cardiovascular physiology. This program is being offered by the Institute for Cardiovascular Diseases at Good Samaritan Hospital, 1033 East McDowell Road, Phoenix, Arizona 85002, on January 10, 11 and 12, 1968. The meetings will be held at Del Webb's Towne House in Phoenix. The program director is Alberto Benchimol, M.D., with guest faculty: William M. Chardack, M.D., E. Grey Dimond, M.D., Darrell D. Fane-stil, M.D., Dean Franklin, George C. Griffith, M.D., Paul Hugenholtz, M.D., Albert Kattus, M.D., C. Walton Lillehei, M.D., Oscar Magid-son, M.D., Alfred Pick, M.D., and Robert L. Van Citters, M.D. This is an official Post-graduate Course of the American College of Cardiology. For information about this program, write to Mr. William B. Nelligan, Executive Director for the American College of Cardiology, 9650 Rockville Pike, Washington, D.C. 20015.

## CLASSIFIED AD SECTION

This classified ad section is provided to give members an opportunity to make known their needs for medical and paramedical personnel. Please address all correspondence regarding insertions to: Robert G. Ogden, Executive Secretary, Alaska State Medical Association, 519 W. 8th Avenue, Anchorage, Alaska 99501.

THE ALASKA STATE MEDICAL ASSOCIATION Physician Placement Service has the following number of physicians listed as interested in practice in Alaska. For names and addresses please contact the Alaska State Medical Association office at 277-6891 or 519 West 8th Avenue, Anchorage, Alaska 99501. Anesthesiology 4, Ear, Nose, Throat 2, General Practice 6, Internal Medicine 4, Neurology 2, Ob-Gyn 3, Ophthalmology 3, Orthopedics 1, Pathology 1, Pediatrics 2, Psychiatry 2, Radiology 1, Surgery General 2, Surgery Pediatric 1, Surgery Plastic 1, Urology 5.

OB-GYN ASSOCIATE opening available; preferable to be board certified, will consider board eligible. Reply to L. David Ekvall, M.D., 207 East Northern Lights Boulevard, Anchorage, Alaska 99503.

GENERAL PRACTITIONER WANTED — ASSOCIATE POSITION: this opening includes plans for a possible future partnership. New office with all facilities available. Contact Royce H. Morgan, M.D., 1844 W. Northern Lights Blvd., Anchorage, Alaska 99503.

THE FAIRBANKS MEDICAL AND SURGICAL CLINIC announces opening for general practitioners, internists, and pediatricians. For particulars please contact the Business Manager, Fairbanks Medical and Surgical Clinic, Box 1330, Fairbanks, Alaska.

FOR LEASE—Joseph M. Deisher, M.D., has an office for lease next to the Seward Hospital. The office is equipped with all equipment necessary to start one doctor in private practice. For further information contact Doctor Deisher at ORME, 901 South Wolcott Street, Chicago, Illinois 60612.

SELDOVIA IN NEED of full or part time physician. Hospital available, living and office quarters furnished—guaranteed salary. Interested physicians please contact: Darlene Kashevarolf, City Clerk, Seldovia, Alaska.

ANCHORAGE MEDICAL & SURGICAL CLINIC announces openings for Internist, General Practitioner, and Orthopedic Surgeon. Would like young men under 40 with military obligations fulfilled. If interested, contact: Howard G. Romig, M.D. 718 K Street, Anchorage, Alaska 99501.

GENERAL PRACTITIONER WANTED — ASSOCIATE POSITION; this opening includes plans for a possible future partnership. New office with all facilities available. Contact Royce H. Morgan, M.D., 1844 West Northern Lights Boulevard, Anchorage, Alaska 99503.

INTERNIST: The Tanana Valley Medical Clinic has an opening for an internist. Would like young man under 40 with military obligations fulfilled. If interested please contact Mr. Al Seliger, Business Manager, 1007 Noble Street, Fairbanks, Alaska.

TOK, ALASKA in need of full or part time physician. Living and office quarters furnished—guaranteed salary. Interested physicians please contact Mr. Larry Bramhall, Tok, Alaska.

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# ALASKA MEDICINE

Official Journal of the Alaska State Medical Association  
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519 West Eighth Avenue, Anchorage, Alaska 99501

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THE COLOR PHOTOGRAPHS of Fairbanks on the cover and center spread were taken by Dr. Nicholas Deely on a return helicopter flight from Bassett Army Hospital, 24 hours after the Chena River had passed its crest.

# DR. WILL H. CHASE 1874-1964

By Howard G. Romig, M.D.

As chance would have it Dr. Will H. Chase and my dad, Dr. J. H. Romig, returned to Alaska in 1906 on the same sailing vessel, The Star of Finland, owned by the Alaska Packers Association. For Dr. Romig this second go in Alaska was occasioned by the Great Fire of San Francisco which had wiped out his newly established medical practice. For the younger Dr. Chase, who first came to Alaska on the Dyea (Klondike) Trail in 1897, it was another wonderful adventure and he was full of vigor and enthusiasm.

On arrival in Alaska Dr. Chase entered the practice of medicine out of public necessity. His entire medical knowledge had been gained while a corpsman with the Army Medical Corps. By 1908 he had settled in Cordova. Here he remained in the practice of medicine until 1962, excluding three years in the Dawson-Yukon territory, one year in Fairbanks, one year in Katella, two years in upper Tanana, and six months in Nome, mostly prospecting.

In 1913 Alaska adopted the "Oregon Code" which gave license to all physicians then in practice under the "grandfather clause". Thus Will Chase became a "Doctor" by law, as did a lady practitioner in Fairbanks, who passed away there in the 30's. Dr. Chase was long noted for his kindness and concern, especially for the poor and underprivileged. He many times put to shame his "superior" colleagues by ministering to "the natives" and all others wretched in spirit and body who were unable to find care elsewhere. He helped bring some 3000 babies into this world in the Cordova area, but was paid for only 150 of these deliveries. Many of Anchorage's present prominent citizens were delivered by this self-taught physician when their families lived in Cordova.

I have never heard a criticism of Dr. Chase

that couldn't be attributed to professional jealousy, either on the part of a young doctor attempting to start his practice in Cordova, or on the part of the older outdoorsmen who resented his fame. As an outdoorsman he was a national figure. He wrote a dozen books on Alaska's wildlife and early pioneers, as well as countless newspaper and magazine articles. His books include "Alaska's Mammoth Brown Bears", "The Sourdough Pot", "Reminiscences of Captain Billie Moore", "Alaska - Her Requirements, Its Possibilities", "The Wolverine", "Man and Beast", "Nature Stories" and "The Trail Blazers of Bygone Days".

Dr. Chase became the first Alaska Territorial Health Commissioner and served eight years as Assistant Health Commissioner, 3rd Division. He was Medical Officer for the Bureau of Indian Affairs for 18 years, Medical Examiner under the Provost Marshall in World War I (1919), Game Commissioner on the Alaska Game Commission for its first six years, and Director of Civil Defense, Cordova area, World War II. He was six times elected Mayor of Cordova, first in 1910-11, and for the last time in 1954, for a total of 16 years in that office. He served as Cordova City Councilman for three years from 1950-1962, was elected Grand President of Pioneers of Alaska in 1938, and was a Past Exalted Ruler B.P.O. Elks No. 1483, Cordova. Born in 1874 in Warsaw, N.Y., he married three times, outliving all his wives.

In 1962 Dr. Will Chase left Cordova. By chance I was aboard the modern airliner with him. He never returned, spending his last years with an adopted daughter, Lorraine Chase Kelly, in Seattle. He passed on October 1, 1964 in Seattle. His memory will live long in the hearts of many "old timers". He was a great man and a great physician.





Brown Bear taken by Dr. Chase on Hinchinbrook Island, Prince William Sound.



A corner of Dr. Chase's reception room at Cordova, Alaska. Showing a portion of his collection of Trophies, the largest in Alaska.



Stampede to the Klondyke on the Chilkoot Pass, the Dyea Trail. On Sunday, April 3rd, 1898, a snow slide occurred at this point burying more than 60 persons. 62 bodies were recovered and probably more that never were.



Dr. Will H. Chase standing by the two beautiful Totems at the entrance of his office at Cordova, Alaska. The only Totems ever found west of the Gulf of Alaska. They were found in the debris of an old communal house. The top represents the Eagle and Moon Tribe, below the inverted Great Bear of the Sitka Tribe, the sides the Whale Clan and the bottom Slaves which used to be held by the Aleuts.

# COMMISSIONER'S PAGE

By W. John Chapman, M.D.

*Commissioner*

*Department of Health and Welfare  
State of Alaska*

The time has come when governmental agencies must provide services to citizens of our nation, States, and localities on an equal and non-discriminatory basis. There are many ways of evidencing discrimination. One of these is by providing presumably equal services on a different quality basis, depending upon the economic situation of the beneficiary. This insidious form of discrimination has been commonly invoked against the welfare recipient. This has eroded this individual's sense of personal dignity. It has forced him into a second-class citizenship status. It has embittered him. All these effects have tended to negate any efforts to assist this human being toward economic independence and rehabilitation. It has made it difficult for him to see himself in a responsible and contributing relationship to his community.

One method whereby this has been specifically fostered is in the field of medical care. In this area, not only have we practised this form of segregation with respect to the recipient, but we have also imposed an economic liability on the practicing physician who cares for this human being. In the past, the State has without question reimbursed drug stores for the retail price of drugs which have been prescribed by these physicians for these human beings in economic need. In the past, we have without question paid hospital bills as billed for hospitalization care as ordered by these physicians for these human beings in economic need. We have then required that the physician provide his professional services for a predetermined fee less than

that which he would normally expect to receive for such care of his private patients. In the health care picture of the individual in economic need, the physician is the sole agency which has been expected to provide this care at a cut-rate level.

This invidious practice of this Department has been a source of irritation to the physicians of this State and, for that matter, the same practice has prevailed in most States in the nation. These physicians have been required, prior to giving treatment to the human in economic need, to ascertain his eligibility and to present his billings on specified bureaucratic forms in triplicate. He has waited, on occasion, as long as six months for payment. All of this has required extra administrative costs and, in some of the larger practises, has actually required the addition of extra personnel to the office staff. All this in the face of the old requirement of receiving less than his usual and customary fee.

Physicians, being also human, have experienced an often unconscious tendency to be less than willing to care for the so-called welfare patient because of this irritation and, indeed too often, harrassment. The human in economic need has recognized a subtle distinction which reinforces and intensifies his own sense of secondary status in his community. The radiation of this discrimination has often resulted in a lesser level of quality of health care - witness the often crowded, impersonal, regimented, public-supported clinics in other States which have too often been the only source of medical care for poverty-stricken people in America.



Alaska can be proud that this has been greatly minimized in our State since the Department of Health and Welfare pays full hospital rates in the community hospitals where these people live. It has allowed them the same medication from the same drug stores and pharmacies used by their more affluent neighbors. It has, in fact, allowed them free choice of physician and it has provided payment for this medical care although, in this one area, at an arbitrarily reduced rate with the resultant subtle discrimination referred to previously.

Through the simple expedient of altering the basis of payment for services provided by physicians in Alaska, I have eliminated this particular area of discrimination directed toward these people in economic need. The State Department of Health and Welfare now pays physicians their usual and customary fees and will accept their billings on their standard billheads. It has made this fee payment arrangement uniformly with all physicians through a simple memorandum of agreement which contrasts with the long, complex, legal contract required in the past. By this one alteration in the basis of payment, I anticipate that the cost of medical care in the State of Alaska for its economically-deprived citizens will decrease, with resultant increase in the level of health for these citizens. The physician will no longer tend unconsciously to place his economically-deprived patient in a separate mental compartment and will have no interference in dealing with him in exactly the same manner as he would his private patient - not only on a clinical level but throughout the administrative functions of his private office. The doctor-patient relationship will be enhanced. There should be a development of a much better rapport, with resultant better response to therapy. This undoubtedly therefore will result in fewer office visits for these patients. It hopefully will result in decreased hospital stay for these



*W. John Chapman, M.D.*

patients, even though the cost of an office visit to the physician, or a hospital visit by the physician, may increase slightly. I anticipate that the overall medical care cost to the State will significantly decrease.

Our memorandum of agreement with physicians in Alaska requests that billings for service be presented within 90 days. This should result in a further reduction in administrative costs to the State Department of Health and Welfare as in the past - possibly also due to what was many times subliminal irritation caused by our procedures - physicians would bill for many visits many months following the date of care, often as an effort to consolidate their increased administrative costs in caring for these people.

Furthermore, we have a reduced need for surveillance of billings since we are no longer required to check the billings, item by item, against an arbitrary fee schedule. Our experience to date is too brief to permit us to see the actual effect on costs. I anticipate that at least a year of experience with this new

basis of payment will be required before we are able to determine the overall effect on the cost per patient for general medical relief.

We continue to need the cooperation of the medical profession and to date we have, in general, been receiving an excellent response to this more professional approach to fee payment. I might point out that in any group of humans there will be those few who, no matter what procedures, policies, or methods are adopted for payment, will attempt to take advantage of the system. But the proper method of dealing with this small group is not to apply sanctions to the entire group since the resourcefulness of this rare misfit will not be thwarted by fee schedules or any other system. Our best method of controlling this

group will be to vigorously seek them out and deal with them individually. We cannot justify bringing into question the professionalism of the vast majority of our dedicated medical practitioners through the ignominious use of fee schedules and other administrative control devices.

I look upon this as one of the major accomplishments of my administration to date and I am confident that it will result in the elimination of an area of insidious discrimination at a reduced overall cost to the State of Alaska. I am also confident it will significantly improve the health status of our economically-deprived citizens through increased quality of care.

#### FOR YOUR INFORMATION--

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ANNUAL MEETING JUNE 5-8, 1968, ANCHORAGE

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## ALASKA STATE DENTAL ASSOCIATION JOINS ALASKA MEDICINE

By action of its executive council meeting in Anchorage, December 16, 1967, the Alaska State Dental Association has named ALASKA MEDICINE as its official journal. The move was in response to the invitation extended by the Alaska State Medical Association and the Editorial Board of ALASKA MEDICINE.

Robert A. Smithson, DDS, of Anchorage was named by ASDA President, Joshua Wright to serve as dental editor on the ALASKA MEDICINE staff. Each member of the ASDA will receive a subscription of ALASKA MEDICINE as a part of his ASDA membership benefits, as is the case for ASMA members.

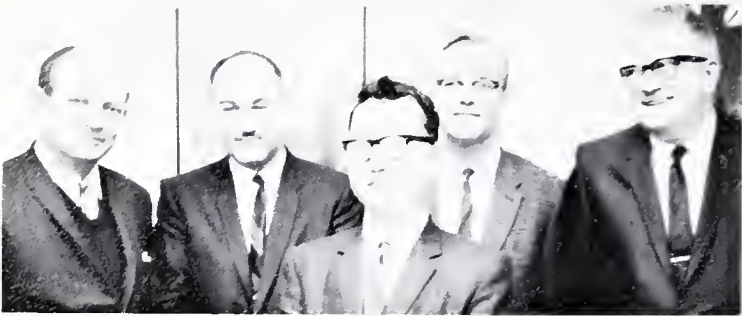
The Alaska State Medical Association will remain the sole owner of ALASKA MEDICINE, with overall editorial and business management responsibility for its publication. The publication of the journal will continue to be under the direction of the ALASKA MEDICINE Editorial Board, Theodore Shohl, M.D., Chairman, and ALASKA MEDICINE Editor Arndt von Hippel, M.D. Funds from our new dental subscribers, and income from advertising directed at the dental profession, will defray the added cost of printing and maintaining the dental section of ALASKA MEDICINE.

I would like to take this opportunity to welcome the Alaska State Dental Association

to ALASKA MEDICINE. In addition to serving as the official medium of communication between the members of the respective professional groups, the new arrangement will fill the communications gap that has existed between the two groups for too long. In this age of "consumerism" and "comprehensive health planning", the need is obvious for the health professions to work more closely together for their own good and for the good of the public.



*Robert B. Wilkins, M.D.*



Left to Right: Raymond Evans, M.D., Fairbanks; Harold Bartko, M.D., Nome; Henry Akiyama, M.D., President, Juneau; Arthur Wilson, Jr., M.D., Ketchikan; Charles St. John, M.D., Anchorage.

On October 19 and 20, 1967 the Alaska Board of Medical Examiners met in Juneau to review and approve applications for medical licensure. During the meeting the Board proposed new regulations relative to procedures to be followed in the issuance of a license to an applicant in the medical profession. In drawing up the proposed changes in regulations the Board conferred with Assistant Attorney General George Benesch, Commissioner of Commerce George Scherrock, former Deputy Commissioner of Commerce Walter Kubley, and personnel from the Central Licensing Section of the Department of Commerce.

H. I. Akiyama, M.D., President of the Board, said that he will request the completed regulations of the Board of Medical Examiners be printed in a future issue of ALASKA MEDICINE.

All members of the Board were present at the meeting and licenses were issued to the following:

Donald Addington, M.D.	Richard Peterson, M.D.
Jon Aase, M.D.	Jon Reiswig, M.D.
Robert Cavitt, M.D.	Robert Stelle, M.D.
Paul Eneboe, M.D.	Glen Straatsma, M.D.
Rodger Haglund, M.D.	Edward Watson, M.D.
Alexander Herland, M.D.	
John Kottra, M.D.	
Lorraine Kottra, M.D.	

## PROFESSIONAL LIABILITY INSURANCE

The ASMA is continuing its drive to obtain adequate professional liability insurance coverage for its members. The Professional Liability Committee, Dr. Charles F. St. John, Chairman, hopes to present a proposal for group professional liability insurance coverage to the ASMA membership at the June meeting in Anchorage. However, more detailed and complete information is required by insurance companies before they can estimate a premium for group insurance. The committee has therefore asked Mr. Robert Ogden to contact each physician individually for the information required. This will be gathered in a confidential committee file open only to the ASMA Council. All information given to insurance companies will be coded.

## LEGISLATIVE COMMITTEE CHAIRMAN APPOINTED

Dr. Rodman Wilson of Anchorage has been named chairman of the ASMA Legislative Committee for the current year. Among the responsibilities of this committee will be to propose needed medical legislation, and to keep the Alaska State Legislature informed of the ASMA's interest in pending legislation. Dr. Wilson, who is also chairman of the Anchorage Medical Society's Legislative Committee, will work closely with other members of his ASMA committee as well as with the chairmen of the various component medical society legislative committee as specified in the ASMA by-laws. Robert Ogden, ASMA executive secretary, will be working closely with Dr. Wilson's committee during the forthcoming session of the Alaska Legislature.



# COMPREHENSIVE HEALTH PLANNING AND PUBLIC HEALTH SERVICE AMENDMENTS OF 1966

(Public Law 89-749)

**By Glenn Crawford, M.D.**

*Chairman, ASMA Public Health Committee*

This legislation, enacted November 3, 1966, is a system of Federal grants for:

- (a) Comprehensive state health planning.
- (b) Area-wide health planning.
- (c) Training, studies and demonstration projects that lead to the development of improved and more effective health planning.
- (d) Comprehensive public health services.
- (e) Health services development projects.
- (f) Interchange of state and federal public health personnel.

The original legislation was for a two year period, from July 1, 1966, through July 1, 1968. Amendments increasing the allocated funds, extending the law for three more years, and greatly enlarging the scope of federal involvement in health care passed the House of Representatives by a vote of 395 to 7, and was reported out of the Senate Committee November 4, 1967.

Despite the vague and almost undefinable term, "comprehensive health care planning", Alaska has begun implementation of this legislation. This state, along with most others, was motivated by part (d), which is not the least vague. It states that effective July 1, 1967, the present system of separate federal health grants will be discontinued. These grants finance the following:

- 1) General public health services.
- 2) Tuberculosis control.

- 3) Chronic disease services.
- 4) Heart disease control.
- 5) Cancer control.
- 6) Mental health services.
- 7) Dental health services.
- 8) Radiological health services.
- 9) Home health services.

In lieu of separate grants, the federal government will make a block allocation to the state for providing these services in accord with the state's comprehensive health plan.

The background for this legislation was published in 1966, and is contained in the Corson report, (the Advisory Committee on Health and Education, Welfare Relationships with State Health Agencies), and in the report of the National Commission on Community Health Services. The need for an integrated approach is obvious when one considers the recent proliferation of federal programs such as; Medicare, Title 19, Heart-Cancer-Stroke planning, plus grants for Community Mental Health Centers, Migrant Health Programs, Air Pollution Control, Office of Economic Opportunity programs for training of the health manpower and neighborhood health centers, as well as the medical programs of the Children's Bureau. The commissions repeatedly stressed the importance of the consumer having an advisory, and in some cases veto position, in the providing and planning for health services.

Part (a) of the law contains the means and

methods for state-wide planning. Each governor is directed to appoint a state planning agent, in Alaska this is the Commissioner of Health and Welfare, and a health advisory council, which must include representatives of state and local agencies, and non-governmental organizations concerned with health. Fifty one per cent of this advisory council must consist of consumers of health services. The state agency and advisory council receive federal funds to establish a program for comprehensive planning and to assist in the development of area and regional health planning.

Part (b) of the law provides for metropolitan or area-wide planning. The state can recognize only one planning agency and council for each area. The area advisory council must be proportioned similar to the state.

Part (c) authorizes project grants to public and non-profit agencies for training, studies and demonstrations that improve comprehensive health planning.

Part (e) of the law supplies grants to public or non-profit private agencies to provide medical services to a limited geographic group, or to undertake studies and demonstrations, designed to develop new methods of providing health services. These grants must be within the scope of the comprehensive plan and are made by application through the state planning agency and the regional public health office.

Part (f) while of limited significance to many states may be important to Alaska. This would allow the state to borrow from the federal government the needed personnel and talent for operating an effective public health program.

Federal interpretation of comprehensive health planning is by no means limited to the traditional concept of public health. It encompasses the present and future distribution and services of private physicians, voluntary health agencies, public and private hospitals and nursing homes, and professional, edu-

cational resources. Health, as a positive concept, not merely the absence of disease, is reflected in the emphasis placed on evaluation of environmental factors that improve health. The official HEW definition consists of four parts.

1) Selecting and applying measures for evaluating the health of the population and for assessing the impact on health status of environmental, social, economic and other related factors.

2) Undertaking studies to define the scope, nature and location of health problems, and to identify and assess the resources available and necessary to solve them.

3) Selecting goals and priorities for solving identified health problems through the use of available resources, or through the development of new resources. Developing both current and long-range policy and action recommendations for meeting the health needs of the people through public, voluntary and private efforts.

4) Developing criteria for evaluating health programs and their contribution to attaining the goals established through comprehensive health planning.

During recent years medical care and good health has become equated with the right to food, clothing and shelter. Public involvement in the distribution and quality of medical care is an established fact and in 89-749 has become a federal law. An active negative attitude toward this social change can be disastrous and lead to loss of physician dignity and leadership. Apathy, while knowledge of this law becomes widely disseminated will lead to consumer dominated advisory councils making unrealistic and unnecessary demands on medical manpower. The private physicians must get involved now and take the initiative in forming and expressing themselves in area and regional planning councils.

As a state medical association multiple approaches need consideration. For example,



the law provides for much of the data gathering, surveying and health evaluation to be done by contract with a non-profit private agency. The physicians in Alaska could be extremely influential by forming a state research and educational foundation for obtaining these contracts. Another possibility for positive action is a project grant for demonstration of the ability of private physicians to provide

medical care to several native villages on a more continuous basis and of a higher calibre than is now available.

These examples were chosen to illustrate how active utilization of this legislation can strengthen the role of private medicine in the rapidly and inevitably changing social attitudes toward health.

## Alaska's Comprehensive Health Advisory Council

Wallace J. Chapman, M.D., Chairman,  
Commissioner, Department of Health and  
Welfare - Juneau.

Robert W. Ward,  
Commissioner of Administration - Juneau.

Glenn Wilcox,  
Coordinator, Office of Alcoholism - Juneau.

Mrs. Patricia Rogers,  
Health Center - Fairbanks.

Thomas J. Moore, Advisory,  
Commissioner of Labor - Juneau.

Ralph Matthews, Advisory,  
Acting Director of Vocational Rehabilitation -  
Juneau.

Rev. William T. Warren,  
Mental Health Organization, Fairbanks.

Mrs. Earl Hunter,  
Alaska TB Association - Juneau.

Robert B. Wilkins, M.D.,  
Alaska State Medical Association - Anchorage.

Mrs. Elva Scott,  
Local Education - Anchorage.

Mel Personnett,  
Commissioner, Department of Public Safety -  
Civil Defense.

Mrs. Elsie Havens Blue,  
Alaska Hospital Association - Anchorage.

Mrs. O. Osborne,  
Mental Retardation Association - Juneau.

Keith Lesh,  
Vocational Rehabilitation - Anchorage.

Gene Morgan - Anchorage, Donald Crad-  
dick - Juneau, Rod Saunders - Anchorage,  
Lloyd J. Sutton - Anchorage, Don Berry -  
Juneau, Walter Bremond - Soldotna, Larry  
Sullivan - Anchorage, Mrs. Emily Savage -  
Anchorage, Leo Rhodes - Homer, Judge  
Thomas B. Stewart - Juneau, Richard Shepard -  
Juneau, Larry Brown - Anchorage and Mrs.  
Carl Webb - Fairbanks, Consumers.

# ALASKA STATE DENTAL ASSOCIATION



## On the Number and Location of Alaska's Dentists

The Alaska Dental Society has just completed a detailed study of the number and distribution of private and federal dental practitioners across the state. These figures have been combined with current data on the distribution of the populations served, to provide an insight into the dental care of Alaskans that has not previously been available. A major stimulus for this investigation has been numerous tirades against the Dentists of Alaska in recent years, alleging callous and restrictive practices to avoid competition. Many communities in Alaska, as in other states, have failed to attract a private dental practitioner by reason of their small size and remote location. Inhabitants of rather large areas may thus have little or no care available to them. Periodically angry noises are emitted from these places. Legislators, who must be attentive to the complaints of their constituents, pass on and emphasize these grievances, and the argument flows anew. Basically the accusations are of "restrictive" dental licensing procedures for Alaska, with allegations of unnecessarily high examination failure rates that result in the unjust exclusion of many eminently qualified dentists, giving an overall inadequate private dentist population for the state.

As is true in all health matters in Alaska, statistics can easily be selected to prove almost anything. This is primarily due to the mutually exclusive federal health facilities available to two of the three major population groups of the state. The large military population of Alaska under present classification as a "remote area" is cared for en-

tirely by military physicians and dentists at military facilities. This "remote" classification holds even in Anchorage where specialists are available in all major dental and medical fields. The large "native" population is likewise provided "free" care by the U.S.P.H.S. Hospitals. It is the non-native civilian who seeks his care from the private dentists of Alaska, a fact that is apparently not widely appreciated. For example, a recent investigation has shown that even the resource figures used by the American Dental Association to arrive at the Dentist-Population ratio, counted civilian dentists only, but included all military and dependents in the civilian population figure. Similar discrepancies are found in statistics compiled by the United States Public Health Service.

The most reliable and current census figures for Alaska are maintained by the Alaska Department of Labor, Employment Security Division, and are used in this analysis. The map shows the Dentist-Population ratio by Election District, further identified by major towns or villages. It shows that the greatest need for dental care exists in the areas where only the U.S.P.H.S. can provide the manpower and resources, yet the greatest concentration of PHS dental personnel is in the area where private offices and contract care are readily available. Likewise of interest is the fact that the Federal Government employs more dentists than there are civilian practitioners in the State. (114 vs. 81). The nationally acceptable ratio of population: dentist is 2,000:1. Alaska enjoys one dentist for each 1387 other citizens; the United States



overall average is 1:1932. The table shows that the areas short of this ratio fall into the province of the Public Health Service. By contracting this "native" dental work out to private practitioners the job could be done, and the cost decreased.

There is an additional factor in this sort of evaluation which cannot be shown on graphs or tables and that is the nature of the practice of dentistry per se. New techniques, instruments, equipment and materials have radically changed dental practice in recent years, resulting in increased efficiency and quality of dental services. Preventive measures have caused a major reduction in the amount of dental disease, and modern dentistry allows the dentist to treat many more patients than ever before. We look forward happily to the elimination of dental caries in Alaska in the not too distant future. Already 70-80% of new decay has been stopped by fluoridation and other preventive measures, in that part of the population we have been able to reach!

An interesting sidelight of these facts is the possibility that even the present dentist-population ratio may not need to be maintained in the future, although federal planners are decrying the lack of new Dental School construction. In fact, no one can now predict what a desirable dentist population ratio is likely to be, even in the near future.

On the Alaskan Dental Board Examination

The task of maintaining and raising standards in the healing arts has two principle dimensions: disciplinary and educational. Ideally these two aspects are combined as in the school environment where coercion may be used when motivation has failed to establish minimums. Over the past 50 years medicine and dentistry have constantly upgraded their schools; first by association with universities and then by standardization of curriculum, admission requirements, and course content.

On the postgraduate level, continued education is advanced through the efforts of professional societies, clinics, lectures and seminars. All of these lend themselves well to the highly motivated individual who participates in them, and brings the knowledge gained into his own practice. The problem, if any, lies with the man not so motivated.

The most effective single mechanism available to physicians in maintaining medical standards is the hospital organization. Here in the focal point of modern medical practice, the most subtle and profound influences are constantly upgrading medical practices. It is the carrot and stick controlled entirely intra-professionally and locally. The medical practitioner who consistently failed to meet hospital standards, in spite of this free association with his colleagues and their ideas, would certainly have his privileges curtailed if not lifted entirely.

Unfortunately there is no equivalent of hospital discipline in dentistry, for practical purposes. Or if you prefer, each dentist establishes, equips, staffs, maintains and supervises his own hospital.

Consequently, dentistry has had to rely more on extraprofessional mechanisms in order to maintain minimum standards. Here I refer to the dental practice Acts of the fifty states, Puerto Rico and the District of Columbia, and the Boards which they create. If a dentist, once granted a State license, is free to practice as he chooses, bound only by his conscience and the broad outlines of the law, then certainly it is in the public interest to examine that same dentist as thoroughly and completely as possible before granting his license. In Alaska this is accomplished as follows:

- 1) A man must have graduated from a school accredited by the council on Dental Education of the American Dental Association.
- 2) He must have successfully completed a National Board Examination in Dental

Theory. This Examination is administered by the American Dental Association at the various dental schools throughout the country.

3) He must demonstrate mastery of various techniques on a patient and the ability to handle various dental materials in the laboratory and in the mouth. This examination is normally conducted at one of the military dental clinics in the Anchorage area, the second full week of each July. The contents of the examination are similar to the requirements of most schools prior to awarding the dental degree.

The men making up the Dental Board in Alaska serve their State and their profession on a voluntary basis without salary. One member is appointed each year by the governor from a list polled from the members of the Alaska Dental Society. Traditionally two

board members are from South-eastern, two from South-central and one from North-central Alaska. Each of these men holds other state boards in addition to the Alaska Board and they are usually from different schools.

The Alaska Board is proud of the quality of Alaskan dentistry. We have a young group of men from schools all over the country who are dedicated to their profession and are continuing their education through regular group study, post graduate courses and by active participation in the lectures and seminars sponsored biannually by the Alaska Dental Society.

Dentistry will face a number of great changes in the coming decade. We can only hope that with the limited tools at our disposal that the standards continue to improve.



#### THE FOLLOWING LETTER TO A LEGISLATOR WAS IN REPLY TO HIS LETTER OF INQUIRY REGARDING ALASKA STATE DENTAL BOARD EXAMINATION—

Upon graduating from Marquette School of Dentistry in 1964, I drove to Anchorage for the purpose of taking the Dental Board. I failed the Dental Board held in July of that year. In September of 1964 I joined the United States Public Health Service with which organization I served until September of 1966. In July of 1965, I failed the Board for a second time. The Board advised me to take a refresher course in operative dentistry as the quality of my work fell below that of the other applicants. Many of the applicants each year come from the West Coast dental schools, e.g. Oregon, Washington and the California dental schools. It is generally acknowledged in dentistry that the most proficient dental operators in the country are graduates of West Coast dental schools. These dental schools work with good equipment, hire excellent instructors and demand their students to

produce a high quality restoration. Because I was committed to PHS duties I did not at that time take the Board's advice concerning a refresher course. I took the Dental Board in Alaska for the third time in 1966 and again failed. In the spring of 1967, I enrolled in a nine-week, postgraduate, dental refresher course given by University of California at Los Angeles. This course is given to help the non-West Coast dental school graduate pass the California Dental Board. In July of 1967, I took the Alaska Dental Board for a fourth time. This time I earned my Alaskan license.

I have prefaced my remarks about the Alaskan Dental Board by tracing my board experiences, because if anyone has a right to harbor bitterness towards the Alaskan Board, it is I. But, on the contrary, I feel a deep gratitude towards the Alaskan Dental Board. They indirectly compelled me to become a



competent dental operator. The nine weeks at UCLA taught me things that four years at Marquette never did.

At the beginning of the UCLA course, each dentist was asked to prepare two dentiform teeth, one for placement of a gold foil and another for an amalgam. These were collected and held by the instructor. At the termination of the course we were asked to prepare two dentiform teeth again, one for a foil and one for an amalgam. We were then presented with both sets. The results of nine weeks training were remarkable. The first attempts might have been done with my pocket knife. The second preparations were beautiful.

My contention is that Marquette failed in teaching me the basic rules of operative dentistry. I don't understand why the Alaskan Dental Board should be punished for the failings of the applicant's school. Through four Alaskan Dental Boards I was able to compare my work with the work of graduates of other dental schools. Only this year was I able to point with pride at my gold foil or gold inlay, or silver amalgam when a graduate of, say, Southern California or Oregon asked to see it.

The statement that the Alaskan Board limits the number of licenses on an arbitrary basis, rather than for substantial cause simply is not true. As I recall, each year perhaps 70% of the applicants received licenses. This percentage of success compares favorably with other Western state dental boards. In fact, this year three applicants were allowed to take another one-half day to recast their faulty gold inlays, as their first casting just didn't fit. If anything the Alaskan Board is more than fair in their examination. If the applicant can do the work, he will receive a license.

Alaska is unique in that it is able to profit by the past mistakes of other states. This is true in conservation, commercial fishing and forestry as well as in dentistry. In Wisconsin and in California, both states which I have lived in and am licensed in, I have seen some horrible examples of dentistry. The people of Alaska deserve high quality dentistry. I am in full agreement with the Alaskan Board of Dental Examiner's licensing procedures. They are doing the people of Alaska a fine service. It is not the fault of the Board that Nome or Big Delta cannot retain a full time resident dentist.

The burning college liberal too often defends the status quo once he is out of school and enjoying financial solvency. Lest you might think my success in this year's board has blunted any previous crusading spirit, let me assure you this is not the case. Never after my three failures did I blame the Alaskan Board. Marquette was unable to teach me the principles of sound dentistry. Only after I was drilled in these principles last spring, was I able to pass the Alaskan Board.

In your letter you say that you are "making a study", yet as I read further it seems like your conclusions have already been established. You state in your letter you are out to abolish the Alaskan Dental Boards. I hope the time I have taken to write this letter has not been wasted, and that it is used in your study, rather than dismissed. Perhaps because you lead me to doubt your objectiveness I have taken the liberty to send courtesy copies of this letter to the State Legislative Council and to the Alaskan Board of Dental Examiners.

I thank you for allowing an expert in the field of recent Alaskan Dental Boards the opportunity to tell his side of the story.



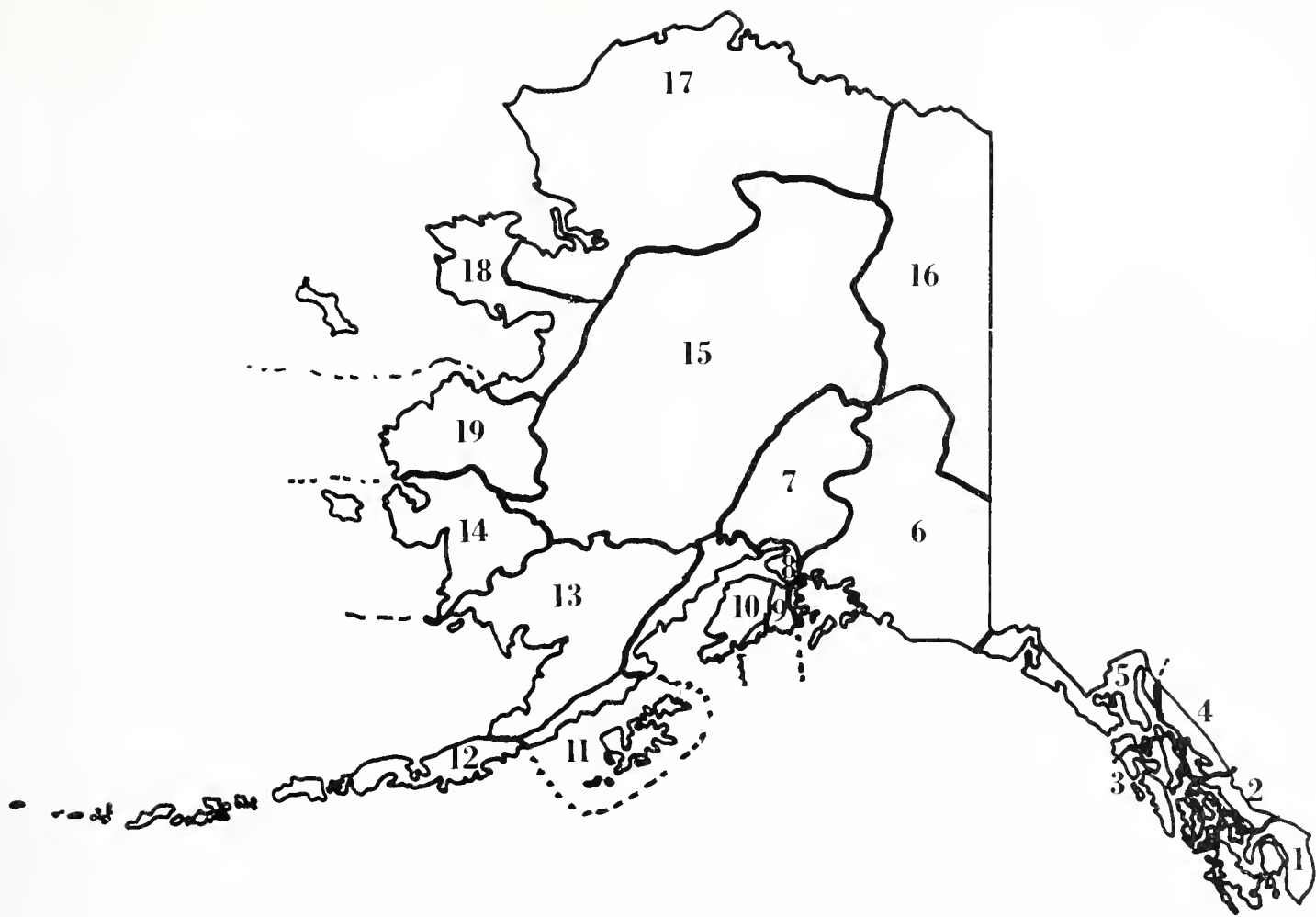
# DENTISTS BY ELECTION DISTRICTS

- 01 Ketchikan - Prince of Wales (5)  
Dr. O'Connell  
Dr. Shepard  
Dr. Stephens  
Dr. Schrupp - U.S.P.H.S.  
Dr. Colley - U.S.P.H.S.
- 02 Wrangell - Petersburg (2)  
Dr. Day  
Dr. Floyd
- 03 Sitka - Mt. Edgecumbe (6)  
Dr. Hodgins  
Dr. Pflugrad  
Dr. Prewitt  
Dr. Johnson - U.S.P.H.S.  
Dr. Nasi - U.S.P.H.S.  
Dr. Ostrander - U.S.P.H.S.
- 04 Juneau (10)  
Dr. Biggs  
Dr. Fraley  
Dr. Horchover  
Dr. Polley  
Dr. Riddell  
Dr. Roser  
Dr. Stewart  
Dr. Williams  
Dr. Benson - U.S.P.H.S.  
Dr. Dumont - U.S.P.H.S.
- 05 Lynn Canal - Icy Straits (2)  
Dr. Sieg  
Dr. McDowell
- 06 Cordova - McCarthy - Valdez - (1)  
Chitina - Whittier  
Dr. Putnam
- 07 Palmer - Wasilla - Talkeetna (3)  
Dr. Carlson  
Dr. McCavit  
Dr. Sims

- 08 Anchorage (44)  
Dr. Lloyd O. Barrow  
Dr. S.W. Bell  
Dr. William S. Bevins  
Dr. Carrol D. Bledsoe  
Dr. Wilbur E. Bline  
Dr. Bob B. Bliss  
Dr. Robert F. Brodie  
Dr. Don E. Burk  
Dr. Joseph R. Cumming  
Dr. Clifford H. Driskell  
Dr. Bryan A. Ekren  
Dr. Lee R. Ellenburg  
Dr. Arthur P. Ceuss  
Dr. C.O. Could  
Dr. Albert J. Grubba  
Dr. Richard L. Hanks  
Dr. Ward A. Hulbert  
Dr. Paul C. Jaeger  
Dr. Lloyd J. Jones  
Dr. Craig S. Kauffman  
Dr. B.D. Layman  
Dr. R.D. Livie
- Dr. Lee L. McKinley  
Dr. John E. Miller  
Dr. Ceraldine T. Morrow  
Dr. Charles A. Munns  
Dr. H.A. Nahorney  
Dr. Thomas S. Redmond  
Dr. A.R. Roberts  
Dr. Martin L. Slisco  
Dr. Robert W. Smith  
Dr. Anthony J. Oney  
Dr. Luther L. Paine  
Dr. Clenn J. Pratt  
Dr. R.A. Smithson  
Dr. Griffith R. Steiner  
Dr. Robt. R. Sutherlin  
Dr. Joshua J. Wright  
Dr. Butts - U.S.P.H.S.  
Dr. Dowd - U.S.P.H.S.  
Dr. Miller - U.S.P.H.S.  
Dr. Christensen - U.S.P.H.S.  
Dr. Jacobsen - U.S.P.H.S.  
Dr. Turner - U.S.P.H.S.

- 09 Seward - Homer (2)  
Dr. Marley  
Dr. Williams
- 10 Kenai - Cook Inlet  
Dr. Bailie  
Dr. Fair  
Dr. Stingley  
Dr. Youngberg
- 11 Kodiak (2)  
Dr. Colford  
Dr. McKinley
- 12 Aleutian Islands (5) USN
- 13 Dillingham (1)  
Dr. Boccaccio - U.S.P.H.S.
- 14 Bethel (2)  
Dr. Chiles - U.S.P.H.S.  
Dr. Lang - U.S.P.H.S.
- 15 Tanana - Nenana - McCrath (2)  
Dr. Carpenter  
Dr. Fink - U.S.P.H.S.
- 16 Fairbanks - Upper Yukon (11)  
Dr. Baggen  
Dr. Cunningham  
Dr. Fate  
Dr. Hughes  
Dr. Kutsch  
Dr. Seeley  
Dr. Simonsma  
Dr. Stealey  
Dr. Willey  
Dr. Smedley - U.S.P.H.S.  
Dr. Sollazzo - U.S.P.H.S.
- 17 Barrow - Kobuk (2)  
Dr. CadBois - U.S.P.H.S.  
Dr. Veazie - U.S.P.H.S.
- 18 Nome (2)  
Permittee  
Dr. Stone - U.S.P.H.S.
- 19 St. Mary's - Hooper Bay (0)





POPULATION-DENTIST RATIO BY  
HOUSE OF REPRESENTATIVES VOTING DISTRICT, STATE OF ALASKA

ELECTION DISTRICT	JULY 1 1966A	TOTAL DENTISTS	CIVILIAN DENTISTS	GOV'T DENTISTS	PHS MILITARY	ALASKA PT-DENTIST RATIO	NATIONAL PT-DENTIST RATIO
ALASKA	271,505B	195	81	22	92	1387:1	1900:1
01 Ketchikan-Prince of Wales	13,794	6	4	2		2299:1	
02 Wrangell-Petersburg	5,287	2	2			2640:1	
03 Sitka	7,301	6	3	3		1200:1	
04 Juneau	13,227	10	8	2		1323:1	
05 Lynn Canal-Icy Straits	3,194	2	2C			1600:1	
06 Cordova-McCarthy- Valdez-Chitina-Whittier	4,405	2	2C			2202:1	
07 Palmer-Wasilla-Talkeetna	6,481	3	3			2160:1	
08 Anchorage	105,925	103	39	6	58	1030:1	
09 Seward	2,239	2	2			1120:1	
10 Kenai-Cook Inlet	9,020	3	3			3000:1	
11 Kodiak	8,479	6	2		4	1410:1	
12 Aleutian Islands	8,087	5			5	1340:1	
13 Dillingham	4,552	1		1		4552:1	
14 Bethel	7,473	2		2		2366:1	
15 Tanana-Nenana-McGrath	7,206	2	1	1		3603:1	
16 Fairbanks-Upper Yukon	46,844	37	9	3	25	1266:1	
17 Barrow-Kobuk	6,525	2		2		3262:1	
18 Nome	6,497	2	1C	1		3200:1	
19 St. Mary's-Hooper Bay	4,967						

- A. Most recent, accurate data available (12/15/67) from Alaska Department of Labor, Employment Security Division.
- B. Population total included military, military dependents, and all natives and USPHS beneficiaries.
- C. Civilian dentist operating on temporary permit.
- Influence of military and PHS eligible persons on civilian ratio difficult to assess, e.g. PHS dentists can care for anyone one-quarter native or more; and non-native wives of native men.
- Military dependents are entitled to care by military dentists because Alaska has been declared "remote area".

# FAIRBANKS FLOOD OVERVIEW

By James A. Lundquist, M.D.

After many days of off-and-on rain which saturated the earth we had four or five days of heavy rain that made a mess of Fairbanks. It has been estimated that the amount of water through the Chena watershed equalled five spring run-offs. The area inundated was 50,000 square miles, equal in area to many of the States to the South.

On 13 August reports from the upper Chena River were that the river was over its banks and washing out roads. Early in the morning of 14 August I checked on the Chena at my house to find it rising rapidly and approaching the edges of my lawn. Reports from the weather bureau and civil defense led us to believe that the river would crest at a level that would not flood most homes, so I spent the entire day plugging drains, sandbagging, and damming only to have the water by late afternoon rise faster than ever. By evening we moved out, abandoning the house to the water which had then flooded my basement. Late the night of the 14th I returned in knee deep water to remove what food we had in the house.

By early morning on the 15th of August I had 10 - 1/2 inches of water through the higher part of the first floor of my home and four feet through the lower part.

Essentially all of Fairbanks and almost all of the surrounding areas were flooded. As water flowed over the higher roads and the railroad line, many areas were flooded very quickly, giving people very little time to evacuate their homes. Many persons were rescued from rooftops. Official death figures are not

available but estimates range from 3 to 17 flood deaths; I am inclined to believe the latter.

It is estimated by Civil Defense that 15,000 people were forced out of their homes, but this is counting only those people lodged at the University of Alaska, the high school, Barnette School, and the airport. When all the others who stayed with high-ground friends (as we did) and who camped out in the hills are added, the total number comes closer to 30,000 people (including those in Nenana - which was flooded over the rooftops).

Of all local medical facilities our offices fared the best in that we were partially staffed and functioning most of the time, although we had a basement full and a few inches of water through the first floor. The Fairbanks Clinic had a basement full and almost 5 - 1/2 feet of water through the first floor. Dr. Storr's office damaged severely. Dr. Bugh and Dr. Weston were kept out of their offices by the high water, although their examining rooms received no damage. Professional Pharmacy opened again the evening of 14 August and was open 24 hours a day throughout the emergency, being the only source of drugs other than the Bassett Army Hospital. St. Joseph's Hospital patients were evacuated to Bassett Army Hospital the night of 14 August.

Fort Wainwright was severely crippled, losing its power, having ruptured steam lines, and no water or sewer. Bassett Army Hospital and staff did a remarkable job with tremendous handicaps and an additional civilian patient load.



During the days of the flood the local doctors had dispensaries operating at this office, at Barnette School, at the Airport, on Farmers Loop Road at the KFAR transmitter, and outpatient and inpatient clinics at Lathrop High School and at the University of Alaska. It is interesting to observe that the fear of a typhoid epidemic that was prevalent south of the Chena River (where typhoid immunizations were given to very large numbers of people) was unfounded. The area north of the river served as a control group in which very few typhoid immunizations were given. No proven cases of typhoid are known to me. Nor were fears of epidemic diarrhea well-founded, for few cases have occurred. Whether infectious hepatitis will be a problem remains to be seen, but little if any is seen thus far.

In my own experience bronchitis and lobar pneumonia have been seen in almost epidemic proportions. Acute pharyngitis, apparently not streptococcal, has been common, also.

The flood provided an interesting experience for all of us here; and, almost without exception, each of the physicians in Fairbanks suffered a significant financial loss. It has been estimated that the flood damage will cost this community \$200,000,000.00. I rather suspect that this estimate covers major physical damages only and excludes the military losses and the loss of personal property and loss of income. I would suspect, all things considered, that Fairbanks and the surrounding country lost \$400,000,000.00 - not an insignificant amount.





# ROUND THE WORLD- THE FAIRBANKS FLOOD

**By Jack H. Petajan, M.D.**

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## Introductory Comment

The 14 August 1967 flood in Fairbanks, Alaska, was of history-making magnitude. The city is accustomed to almost yearly flooding during the spring thaw when melting ice and ice jakes on the Chena River cause water levels to rise above flood stage. Nearly a month of virtually continuous rain between mid-July and mid-August, equivalent to the melting of 50" of snow in one day, caused a steady rise of the Chena and Tanana Rivers between which the city lies. Time and height predictions of the river's crest were totally inaccurate and thus most people were caught unaware by the icy cold water which rose many feet above any previous flood level. An area the size of the state of Alabama was inundated. Only a few individuals escaped having the first floor of their homes awash, and major structural damage was commonplace. Many basements collapsed, houses were moved off foundations, and basement floors were heaved up. In some cases, houses were simply washed away.

The Fairbanks area includes about 45,000 people--all of whom were affected by the flood. Patients in the local hospital, located on the Chena River, were evacuated to the Bassett Army Hospital which was without heat, water, or sewage facilities and operating on emergency power. People sought refuge in the surrounding hills, primarily at the University of Alaska, in College, which was a shelter for approximately 10,000 people early in the

disaster. The local high school, which is upon slightly higher ground but still on the flood plain, became the shelter for about 6,000 people. Other schools sheltered smaller numbers of people. Since Fairbanks lies in the midst of a vast unpopulated area, there are no nearby communities to which residents could be evacuated. Children and the ill were evacuated to Anchorage by plane. Anchorage extended a warm life-saving hand to Fairbanks by caring for its children and sick while the city struggled to regain its footing. All people not directly concerned with rehabilitation efforts were encouraged to leave. Repeated earthquakes, although called small aftershocks of the June quake, served to heighten anxiety, especially since many homes were held up by temporary supports.

Evacuation of people to shelters was accomplished by riverboat, heavy trucks, and helicopters. Alaska riverboatmen, accustomed to navigating in rapidly moving water, were responsible for evacuating many people stranded on rooftops and in dwellings soon to be made uninhabitable by the rising water. It is truly amazing that only six individuals lost their lives as a result of the flood.

The following account is a physician's view of the disaster as experienced in one of the shelters (the local high school) and is presented not as a detailed description of the disaster but rather as a personal experience which may assist other physicians forced to manage themselves and others in a disaster.



## Clinical Comments

Reliable information about the early stages of a disaster is hard to obtain. People react to situations as they arise with little concern for records or administrative organization. They become unaware of the passage of time as they deal with medical crises facing themselves and their community. On 14 August, the water reached our neighborhood and in the early morning of the 15th, it was necessary for my family and me to evacuate a badly-damaged house, which at any moment seemed ready to collapse into the basement as two walls had fallen in. Several families in the neighborhood were evacuated to a neighbor's house on higher ground. Using a small boat, we brought people to this place. Men continued to work in their homes to save whatever possible until evacuation was absolutely essential. Final evacuation to Lathrop High School, about a half mile from my home, occurred on 15 August around 5 a.m. After becoming settled in a schoolroom with neighbors with whom we had only had previously casual relationships, I left my family to become involved with the medical problems of 6,000 refugees.

The school nurse's office became our clinic. It contained a dispensary, two single bedrooms, a washroom, and an anteroom. During its earliest operations, patients crowded into all recesses of the clinic. No triage of patients was done, and patients with minor problems impeded aid to those in more serious difficulty. With the help of excellent nursing management, a waiting area was established outside the clinic and a separate room was set up for immunizations. A medical secretary volunteered to help with record keeping. By the second day, a mimeographed form was used for keeping patient records. Working in shifts, four physicians kept the clinic operative 24 hours per day. Evacuation of a local convalescent home and the natural

occurrence of more serious problems led to the establishment of a 20-bed ward in the home economics room. Volunteer nurses from Anchorage served this ward in excellent fashion. A smaller room nearby became an isolation ward where whole families with acute infectious disease, such as rubella, could be isolated.

## Clinical Aspects of the Disaster

Several clinical problems arose, most of which could be predicted from the following factors:

1. Withdrawal from drugs, especially alcohol.
2. People living closely together
3. Stress or exhaustion from unaccustomed physical exertion, cold exposure, trauma, starvation, loss of sleep, and sustained excitement.

## Seizure Disorders and Diabetes

Within the first 24-48 hours, six patients had grand mal seizures. In four of these, withdrawal from alcohol was clearly implicated; in one, suspected; and in one, a history of neurological disease was present.

Fortunately, medication was available for epileptics (three cases) and diabetics (three cases). Insulin was supplied by boat to diabetics within the vicinity of the high school.

## Trauma

During the first five days, as many as eight hand or foot injuries were seen per day. A total of 106 cases of such injuries were treated. Individuals walking barefoot or sustaining even minor abrasions all developed areas of extensive cellulitis about the wound; and in some instances, multiple cavernous abscesses were seen, especially on the heel or ball of the foot. Lacerations recently sutured

also became infected upon immersion in the contaminated water. Fifty-eight head injuries were seen, most of which were lacerations.

### Upper Respiratory Infections

One-hundred nine upper respiratory infections were treated, 46 of these being pharyngitis. A high number of cases were seen during the first four days and then again approximately one week later. On the basis of eight cultures taken, possibly 1/3 of these were caused by alpha hemolytic streptococcus. All patients with fever and pharyngitis were treated with penicillin whether or not an exudate was present.

### Immunization Procedures

By the third day, it was decided to immunize the population against typhoid. The decision was based on the following assumptions:

1. A significant segment of the population had been evacuated from areas outside the city water supply.
2. Many individuals had swallowed grossly contaminated water or had exposed open wounds to it.
3. The period of confinement of the population was uncertain.
4. If the disease occurred, it would no doubt go undetected for a significant period of time before treatment could be initiated.
5. Statements about the absence of typhoid or paratyphoid in the arctic cannot be reliable because Alaska's population is small, and disease detection in outlying areas is unsatisfactory. Fever, malaise, myalgia, and mild diarrhea constituted the primary response to the immunization. In infants, fever was the primary problem. No serious complications resulted.

Many people reported not having received polio immunizations. Tetanus toxoid was given to all trauma cases and otherwise on a voluntary basis. Polio and paratyphoid immunizations were not immediately available.

### Psychiatric Problems

Emotional stress reactions were surprisingly few in number--only ten cases requiring medical treatment. The most common causes of panic resulted from being isolated in a flooded building, from grief over the loss of a relative, or from the inability to find a relative. In women, conversion reactions predominated, while in men, somatic complaints or exacerbation of some previous chronic complaint occurred. In extreme agitation, trifluoperazine was given intramuscularly, 25-50 mgm, since it was the only drug available; and the patient was immediately made ambulatory after being encouraged to express his feelings. Immediate return to normal activities as soon as possible without reinforcement of symptomatology was found to be most effective, provided levels of anxiety could be controlled. Fatigue and breakdown of integration were seen in several workers who, as a result of sustained excitement, were without sleep for three to four days. Some had to be rather firmly removed from their positions in order to rest. In any disaster, it is essential to have duplicate administrative staffs with an efficient means of passing on responsibility, since work goes on for 24 hours per day.

During the disaster relief operation, the physicians were subjected to the same stress factors as were the other relief workers. Although perhaps more accustomed to pacing themselves for long tours of duty, loss of personal property and damage to their homes created additional anxiety. Virtually continuous activity lasted for about four days with the awareness of the passage of time greatly



impaired. Three weeks passed before any semblance of a normal familiar schedule of living was achieved. Even now, in retrospect, the experience has a very unreal quality.

### Gynecological Problems

These are of some interest since with the advent of the "pill", a new disaster hazard presents itself. Most women were without their medication and began to menstruate within three to four days after arrival in the shelter. A sudden great demand for sanitary napkins developed which, fortunately, could be met. All pregnant women were required to register but no deliveries occurred in the shelter.

### Exposure

Cold exposure produced lethargy, nausea, and anxiety. Rescue workers spent many hours wading in cold water, and many refugees had to literally swim to safety dressed very lightly. In most cases, hypothermia (95-96° F) went unrecognized as the primary cause of the symptoms. Cold exposure was a common accompaniment of injury, fatigue, etc. A hot shower and warm blankets produced complete relief of symptoms.

### Medical Service to Outlying Areas

Occasional calls to visit individual patients or groups of people living in apartments were received. Doctors were flown by helicopter to visit women possibly in labor, with suspected complications, and to see patients in other disaster centers who required a specialist's attention. Immunization teams visited outlying areas in which wells were contaminated. People living in houses or apartments without heat, light, water, or sewage were probably under more stress than people living in disaster shelters. It was common,

however, to view the shelter as a "last resort", and to withstand as much inconvenience as possible before entering it. From our visits to people outside the shelter, it would seem indicated to establish basic criteria for satisfactory shelter and move people from their homes if such criteria are not met.

### General Observations

#### Communications

For practical purposes, almost complete isolation seemed to exist for the first three days. Emergency radio calls for drugs and supplies were somehow answered, but messages were often garbled. It became apparent that medical decisions involving the Lathrop population would rest on the shoulders of the four attendant physicians. The immunization program, when to use chemical toilets, the safety of the water, handling of contaminated food, management of stray animals (three dog bite cases resulted from animals being kept in the building), handling of garbage etc., all had to be dealt with on local level. Communications were gradually established with other shelters, making comparison of management techniques possible. Major differences in immunization programs and levels of medical management seemed to exist depending upon available facilities.

#### Sociological Factors

With the rapid organization of emergency control, a social structure of great interest develops, accompanied by anonymity and loss of accepted social stratification. This situation permits certain individuals to act quite "out of character" and remain unnoticed. It also permits them to satisfy needs which, under normal circumstances, must remain repressed. A sporting goods salesman becomes a fine ward attendant, manifesting a

concern for the welfare of his patients and an attention to clinical detail rivaling that of a registered nurse. A nightclub entertainer (a-go-go) becomes editor of the paper and assists in the child evacuation program. A woman subject to chronic depression and psychosomatic complaints feels better than she has in years while caring for sick children. An amusement park operator becomes an efficient police chief and works himself to exhaustion.

Individuals customarily in roles adaptable to the disaster situation find solace and escape in doing familiar work, but their families are left alone to face the full impact of the damage.

## Final Comment

The transition to a normal community life is still in progress. Many have lost their homes and none are available to replace them. The population of Fairbanks may decrease as much as 20 per cent. Cold weather is rapidly approaching, and people are working frantically to winterize before its onset. Occasionally earthquakes occur which add to the tension. Two local clinics are back in operation, and the local hospital has been partially rehabilitated.

The depressing effect of the flood lingers on. Although desperately needed the community has not been willing to finance a new hospital. It will be many months before the full effect of the flood can be accurately assessed.







## LUCTOR ET EMERGO\*

By Nicholas Deely, M.D.

August 14th appeared, basically, to be a usual day as far as the office practice was concerned, except for the fact that during the ensuing week I had a heavy schedule at the office. School examinations plus cardiac evaluations in preparation for the visiting Mayo Clinic Heart Team contributed to the stress. The only distressing thing environmentally was that we had had rain for a prolonged period of time and it was still coming down very heavily. After making rounds at St. Joseph's Hospital, which is on the banks of the Chena River, I became aware that the level of the river was much higher than usual and that some of the outlying areas had begun to flood over. However, at best it did not appear to be any more than a nuisance situation, except for the very few individuals who at this time were involved. I stopped on the Chena River Bridge and took a few pictures for posterity's sake and also as documentary of some of the activities of the day.

Shortly thereafter, I settled down to my usual office practice, but after approximately an hour or two I came to realize that although the schedule was still reasonably heavy it was not as bad as I expected. By noontime the patients had thinned out to such a degree that it had become quite noticeable. Since it was still raining quite heavily curiosity got the better of me as to the flood situation, so I decided to trot down to the Chamber of Commerce Building which stands along the Chena River and watch the activities. Standing along-

side of me was a tourist from Los Angeles who was not particularly upset by having his initial vacation plans halted by the persistent rain, but who was somewhat concerned about his plans for the following day. He had planned to fly to Kotzebue and points north and had been led to believe that these plans might be temporarily changed. I made a few suggestions for explorations throughout the community and also invited him to visit our Clinic so that he could see firsthand some of the medical facilities in the "far North". Little did I realize that approximately twenty-four hours from this moment he would need a submarine or snorkle to even begin to approach the Clinic.

I returned to the office and was absolutely flabbergasted by the cancellations that had occurred during the noon hour, and also by the very few stragglers who subsequently came in. It was now approximately 3:30 p.m. and word had been received that the Cushman Street Bridge had been closed (the Wendell Street Bridge had already been closed) and that the last remaining link with the north bank, the University Bridge, was also to be closed. Mind you, even at this time the full impact of the impending disaster had not begun to permeate my mind or even to be of any great concern to me. All activities appeared primarily to be of a precautionary Civil Defense nature and my concern was primarily curiosity. In view of the radio message relative to the possible closure of the last bridge across the Chena River, and in view of the

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\*"We shall emerge"

fact that I was doing nothing else but fraternizing with the nurse, I felt that I should go home and take care of any matters or problems which might occur there. As I left the Fourth Avenue exit of the Clinic, I was surprised by the curbstone depth of the water which had accumulated here and also by the curbstone depth of the water at the corner of Fifth Avenue and Lacey Street. Once again I pulled out my camera to take a few pictures as documentary evidence of the community concern that had prevailed during the day. It was still raining rather heavily and I had to make a few leaps and jumps to get to my automobile because of the extensive pooling of water. It was then that reality to a certain degree gripped me as to the potentially dangerous situation which could envelope the community. I immediately returned back to my office, opened my medical bag, and began to sort out what I felt would be important drugs for any possible emergency. I cleaned out my drawers of antibiotics, cough medicines, analgesics and also brought out some syringes, tape and some dressings.

My trip home to College, which is approximately six miles from town, was very uneventful. Although the Chena River was rather high at this time, the University Avenue Bridge was in no apparent danger. I was a bit concerned, however, about some of the low-lying homes on the North bank of the river at the University Avenue crossing, and thought perhaps, if anybody, these homes would be in danger. Ironically, one of these homes on one side of the bridge suffered very little damage, even though it was directly on the river. The homes directly in back of these homes and further north along University Avenue were very heavily damaged and were, in some cases, destroyed. By the time we had the usual household conversations about our home and any possible flood situation in town, dinnertime had arrived and the home conducted itself in its usual normal routine.

Broadcasts periodically brought out statements of flooding throughout the community, but nothing to strike the imagination severely. We kept on listening to news reports until about 1:00 a.m. Tuesday, which was August 15th. Even then, as far as I was personally concerned the flood might as well have been off in China somewhere. We had power, we had heat, and although the rain had been falling for several days the only place that was wet was the roof of our home. No puddles had accumulated around the house and we had not even suffered surface damage from the rain water.

About this time (1 a.m.) I was asked to see a patient and proceeded down University Avenue. As I crossed College Road it was then and only then that the full impact of the severely critical situation that now existed in Fairbanks hit me. Before me was a great deluge of stinking, dirty water pouring over the road and creeping northward at a steady clip. I dashed into the patient's home, saw the child, made the necessary recommendations and prepared to leave. As I left the home, immediate fright struck me, for in the short interval that ensued during the house call, the water had now poured across the road just North of where I had parked the car. Although we were still high and dry in this particular location, water had now surrounded the patient's home, the neighbor's home, and my car. These people made preparations to leave for the University and I, as quickly as possible, headed for my home to begin what became a very eventful seventy-two hours.

Being an Alaskan and living in the Fairbanks area, it has always been apparent to me that we were living in a state of perpetual disaster. In all of our Civil Defense discussions I had always feared Nature and her elements and the consequential action which might have to be taken with respect to power, heat, exposure and communication. Unfortunately, some of these problems have never



been resolved on a community basis, but I have been able to resolve some of these problems for the personal safety of my family and home. As one of these precautions I have always kept stored, in a cache-type setup, additional drugs in the form of antibiotics, antitussive agents and analgesics. Knowing the pharmacology of these agents, one can derive many additional uses for them. Along with this, I had the usual setup of instruments, syringes, splints (which I had made up from apple crates), dressings, etc. I broke open the cache and prepared these supplies for immediate use. Further, cognizant of the disaster hitting Fairbanks and remembering my Civilian Defense post, I went up to the Dispensary at the University of Alaska. Although I saw people milling about, the Dispensary was entirely empty. Here was my first realization of the importance of COMMUNICATION. I later found that approximately two buildings over Doctor Worrall (Ob-Gyn) was in the process of establishing a top-notch emergency medical aid station. During this brief period of pondering, the first of what appeared to be hundreds of calls for my services came over KFAR radio station. Having had the privilege of serving some of the people from the KFAR staff before the flood, they were well aware of the fact that I was in proximity to the transmitter from which they were now broadcasting. Upon answering this summons, I further realized that this could be a point for establishing a dispensary, as KFAR was our communications lifeline. Ruth Benson, of the Alaska Nurse's Association, offered her services and with the aid of my two children, Bonnie Jean and Dwight, we broke in our regular camping gear...tents, cots, blankets, etc., and set up a dispensary at the KFAR transmitter in College. Subsequently, The Alaska Army National Guard left at our disposal two additional tents for medical services. Immediately, my cached medical supplies went into

use. However, I thank God that we never were involved in any serious problem that could have proved these supplies insufficient. After what seemed to be endless calls and wasted effort running about and around the countryside in College and Ester, our activities finally became centralized in one focal point where medical and surgical problems could be handled quickly and efficiently. Nurses in the surrounding areas quickly came to this center where they performed with the greatest sincerity, effectiveness and love. Doctor Jim Lundquist (G.P.), followed by Doctor Bill James (Pediatrician) checked in, and we set up a rotation system so the dispensary would be covered at all times. The nurses, accordingly, also set up a rotation system whereby there were two or three nurses present at all times at the dispensary. As problems arose, both medical and regarding public health, certain bits of information were transmitted by KFAR as a guide and aid to the community. Most of this, as you may have guessed, was related to immediate care and hygiene of infants and children.

As stated previously, we were very fortunate in not having any severe epidemics, traumas, or severe isolated medical problems. One incident of perhaps unusual proportions, was a case of rat bite which probably would not have happened had the flood not occurred. The case involved a child who was living at the transmitter station of KFAR and, as you might expect, the situation was entirely foreign. The lad was treated with penicillin. Rat bite fever was explained to the parents and the child was watched very closely during the flood and immediately thereafter. Fortunately, there was no further problem in this regard.

Typhoid immunization became of great concern during this disaster, involving principally the need and the desirability of immunization. Unfortunately, there was no set policy among ourselves, as far as I could

muster, as to whether or not they should be given. Personally, I had reservations about community-wide immunization because of the following circumstances. People were living under stressing conditions, close quarters, and under poor hygienic conditions. There had been no recent history of typhoid in the community and, as I was informed, samples of the flood waters proved to be negative for typhoid. While I realized that this was not an absolute in itself, I felt that the sequelae associated with hyperpyrexia, particularly in infants and children, could present quite a problem. Therefore, as effective typhoid immunization involves a series of shots, and as hyperpyrexia could most certainly emerge from these immunizations as a nasty problem especially with infants, I decided, unless specifically indicated, against mass immunization. This feeling was also independently confirmed and concluded by some of my colleagues. It turned out that we had no typhoid. In fact we had no significant enteric infections whatsoever. We did have, however, a problem with hyperpyrexia and impending convulsions with those children who were so immunized.

One of the interesting sidelights of the flood was that I had a radio call from some desperate parents whose child had been vomiting for several days. The child was four weeks of age, male and apparently growing quite well. My initial diagnosis, after being airlifted out by helicopter, was that of pyloric stenosis. This was subsequently confirmed by further studies at Bassett Army Hospital. The lad underwent surgery and I now can report a normal, healthy boy. However, getting back from Bassett was another task in itself. One had to hitchhike his way back by wading through water, getting lifts from passing boats, and in some cases where it was dry, short trips in six by six Army trucks. Coming down Cushman Avenue in one of these boats we came across a very heavy woman who

waved us down. We went ahead and hauled her aboard as though she were a large, dead fish. After much tugging and struggling she finally flopped into the riverboat. With a great sigh of relief and with some frustration, the coxswain of the riverboat asked the lady where she was going. She explained that she wanted to be dropped off at Foodland. To this the coxswain replied, "Lady, do me a favor. When you get down to Foodland please get some Metrecal".

It is important to note here that the pillar of the medical setup in Fairbanks was unquestionably Bassett Army Hospital at Fort Wainwright. Our assurance to the patients, our confidence in ourselves, and our ability to act was predicated on the assistance, cooperation and concern of this military medical staff. The citizens of Fairbanks and the Fairbanks medical personnel both owe their undying gratitude to Bassett Army Hospital.

With Helicopters buzzing all over the town it was easy to evacuate seriously ill patients to Bassett, although hard to get back. Helicopters would frequently land at KFAR with messages and drugs. One great helicopter burst through the clouds, hovered for a moment, and then landed so near the dispensary that our tents almost took off. As I hastened over, a prominent city official leaped out, clutching a package of emergency medicines. He handed the bundle to me with apologies for the delay and then left in an equally dramatic fashion. I quickly opened up the first bag and to my surprise there was my "emergency drug"... a box of Ex-Lax! True, additional bags of medication were sent from Bassett and the Red Cross which contained important antibiotics, etc. However, the first bag left a lasting impression. As a matter of fact, by the grace of God, our medical problems were of such a mundane nature, and we were so free of any great accidents or medical emergencies that, ultimately, the biggest



call for medications came to be laxatives and oral contraceptives.

While much of the community was located in refugee centers, a large part was also camped out, in military fashion, on the surrounding hills of Fairbanks, and also in many private homes. Our home was no exception ... a situation which almost made me a stranger in my own home. Returning after forty-eight hours of service "in the field" to shower up, I was met by two bright-eyed lads who started at me and then stated, "Hey, Mister, we live here. Where do you live?" Laughing to myself, I stumbled down to the bedroom to prepare for a shower. I put my arm around my "wife", proceeding to give her a big kiss, and there, staring me in the face was a strange woman wearing my wife's bathrobe. I ask you, who else would you expect to find in your bedroom but your OWN wife? Such were the many exotic sequelae of the flood.

It suddenly became apparent to me that there were possibly other doctors on the so-called "North Shore". Thanks to the complete cooperation offered by KFAR, I placed a message over the radio asking all doctors present here to please come to the Uni-

versity so that we might become fully organized. As stated originally, Al Worrall, had already done a masterful job in getting the Dispensary at the University going. We all met in the basement of what was now the Out-Patient Dispensary and unanimously elected Al Worrall to be our leader. From this time on, all physicians who were on the "North Shore" of the Chena River became completely organized and had complete control of any and all medical, surgical, obstetrical and pediatric problems. Further, from this time on, it was simply a question of waiting for the water to recede and how to meet with what was expected to be (and was) a growing problem of anxiety, fear and frustration. However, at no time were there any signs of panic... food and clothing that was distributed by the Salvation Army and Red Cross were taken only as needed, and there was no evidence of any hoarding.

So it was, on August 14, 1967, that the people of Fairbanks, by their own action and by their conduct under stress, in this the greatest disaster that has ever hit this community, remained a credit to themselves. And while they lost everything else, they emerged with great self respect. *Luctor et emergo!*



# MEDICAL ACTIVITIES— UNIVERSITY OF ALASKA FLOOD REFUGEE CENTER

By Joseph A. Worrall, M.D.

The undersigned arrived at the University of Alaska at approximately 2 a.m. on August 15, 1967 after having been evacuated from his home. The following morning I determined that a medical facility was being set up in the College dispensary. On arriving at the dispensary I found several nurses already there and medical equipment and supplies in place. The facility was a small cottage and was quite adequate. Also present was a civilian tourist physician who was here on a hunting trip. In a short time we had a full complement of personnel including physicians, pharmacists, nurses and lab technicians. Patients were seen almost immediately starting on Tuesday morning, the 15th of August. Drug supplies were obtained initially by the nurses and pharmacists going to their drug stores or to St. Joseph's Hospital and carrying back items that were needed. These people are to be commended for their spirit in making the difficult and dangerous trip into the flooded area to obtain needed supplies. At no time was there any significant shortage of supplies and esoteric drugs needed for individual patients could be obtained. I have in mind a physician tourist who did not work at the dispensary but did visit us and ask for a particular Pilocarpine preparation and also a particular long-acting nitroglycerin preparation for his own use. These medications were obtained without difficulty.

A nursing service was organized by the appointment of a chief nurse who immediately delegated duties and drew up duty rosters. The physicians drew up a duty roster so that

there was twenty-four hour coverage of the dispensary.

An infirmary in Wickersham Hall gave us a twenty-bed holding capability. Communications with Bassett Army Hospital were adequate and helicopter evacuation could be obtained whenever necessary. We had the capability to do obstetrical deliveries if necessary. There was one delivery in a dormitory, attended by a nurse. Several women were evacuated to Bassett in early active labor.

Minor surgery could be performed at our dispensary and at no time did the undersigned feel that our medical capability was inadequate, nor did I feel that there was need to establish the Civil Defense hospital at the University of Alaska.

The public health functions at the University were not ignored. We enjoyed full cooperation from the University officials in such matters as sanitation of the dormitories, the control of the very large dog population and testing of water supplies. We anticipated a rat problem at the University because of high ground. Many rats were reported at the University dump, but to my knowledge only one rat bite occurred and this was not at the University. I heard no reports of increased rat sightings at the University.

We did not experience an outbreak of enteric disease. It was my impression that superficial skin infections were quite common, presumably due to the fact that many minor cuts and bruises sustained during the flood and during evacuation operations became



contaminated from the water and could not be treated with cleanliness and dressings.

The inhabitants of the Pioneer home were evacuated as a body to the University, but were both physically and administratively kept separate from the rest of the medical effort at the University. They had their own nursing staff, but did depend upon us for supplies. Our doctors made rounds at the Pioneer facility. Things would have been better if I had been able to completely incorporate the Pioneer Home activities with our other medical activities at the University.

Complete records were kept on each patient and accurate statistics were developed concerning the number of patients seen and the number of patients evacuated and hospitalized in the local infirmary. The local infirmary had its own nursing staff and its own chief nurse, but functioned closely and in co-operation with our overall medical effort.

One problem was the question of typhoid immunizations. At the University we elected for some time not to give immunizations. One reason was the fact that Doctor Chapman did not feel that it was the thing to do at that time. However, public pressure became so great that we decided to hold a mass inoculation program and this was done without difficulty. Due to a failure on my part Doctor Deely at his dispensary on Farmer's Loop Road was not notified of our change in plans so at one point we had one medical facility giving the injections and another medical facility not giving them. This same problem existed in Fairbanks as a whole, because long before we were giving inoculations we had heard that they were being given at other sites on the other side of the river.

The major problem was communications. I personally had a citizens' band walkie-talkie and also a portable radio-telephone. Nevertheless, it was almost impossible for me to communicate with Doctor Evans or with any of the doctors across the river and I believe

that, considering the Fairbanks area as a whole, Doctor Evans could have done a better job of utilizing the medical resources if he had had a reliable medical communications network. I recommended that the physicians of Fairbanks give consideration to establishing a citizens' band network. If each physician in town purchased a high-quality citizens' band radio which had the capability of being used either as a base station, as a mobile unit in his auto or as a hand-held unit with supplementary battery power there is no question that all physicians in the community could communicate with each other from any place in the community. In Fairbanks the activity on the citizens' band channels is quite light and even during the flood it would have been no problem at all to obtain the cooperation of the Citizens' Band Radio Clubs and designate one of the twenty-three citizens' band channels as a medical channel. Such a communication network would require a base station with a net control, but this could be easily established. Furthermore, I feel that these physicians would find that having a citizens' band unit in their automobile would be a great help to them in their practice, particularly if they established a base station at each of the various clinics. The cost of such a unit would be reasonable, being perhaps \$225 to \$250 for the mobile unit and an additional amount for the base station and base antenna.

In summary, I feel that the medical activities at the University of Alaska were entirely adequate to meet the emergency. No patient was denied needed care of whatever complexity including general surgery. Evacuation was superlative at all times and there was no shortage of physicians, supplies, equipment, nurses, secretaries and pharmacists, nor was there any shortage of laboratory capability. The only recommendation is that the medical profession in Fairbanks make efforts to establish a medical communications system.

# FLOOD WATCHING FROM ST. JOSEPH'S HOSPITAL

By Sister Conrad Mary, FCSP

*Administrator, St. Joseph's Hospital*

On Monday, August 14, the rain was still coming down hard. A favorite pastime of the day was to stop at a window and watch the river rising over its banks onto the lawn. Early in the afternoon sand and bags were dumped at our door. Literally hundreds of people came to help and quickly a three foot high sand bag dike was erected all around the hospital. This was reinforced with heavy plastic and for a while was almost water proof. Our chief engineer kept the boilers on low steam pressure all day. At 4 p.m., as the waters rose more quickly, he stopped the fires and began the process of cooling off the boiler.

Jack Murphy, Fairbanks Civil Defense Director, had been over during the afternoon to see about the need for possible evacuation of the hospital. One doctor, remained on duty in the hospital. At 8 p.m. Mayor Boucher and Mr. Murphy returned, advising evacuation of all patients to Bassett Army Hospital. Dr. Kowalski went around to see all patients while the Sisters and nurses were busy making adhesive tape markers for the forehead of each patient. When the patient was ready to go he was wrapped in a blanket with his chart and medicines, and conducted to waiting vehicles. The newborn babies were put in the arms of their mothers. Two premature infants were carried out in their isolettes with nurses to accompany them. The patients were transported by ambulance, taxi, and private car, the last patient getting across the bridge just before it was closed to traffic. Many volunteers helped with the evacuation and the sixty-three patients were out of the hospital within one and one-half hours.

While patients were being evacuated from

the upper floors others tried to rescue essential supplies from the basement storerooms. Materials brought up both elevators were dumped in the kitchen and the cafeteria. At 2 a.m., with more than a foot of water in the basement, our engineer ordered everyone upstairs and turned off the electricity. In a very short while the lower level filled with water to within inches of the first floor.

During this time the first helicopter landed on the roof to pick up equipment and supplies. The Bureau of Land Management provided our first walkie-talkie. We were called time and again for medicine, syringes, needles, diapers, dressings, and blankets—any need that we could fill from our hospital, by now sitting in about ten feet of water.

For about a week the census in the hospital ranged from 12 to 16. The Sisters, one doctor, a few of our help who were unable to get home, and three engineers. Our duties were to man the walkie-talkie, tour the hospital to make certain it was still solid on its foundations and to watch for possible electrical fire (even though all electricity had been cut off).

With no heat it was bitterly cold. We wore as much heavy clothing as we could find and used blankets to keep warm. For lights we had flashlights, candles and two kerosene lamps.

Coffee water was heated on the bunsen burner in the laboratory, as well as soup to eat with our sandwiches. Those who came to our door by boat or on the roof by helicopter were treated to a hot cup of coffee also, and a sandwich if they had time.

On Saturday we realized that the Thrift Shop behind the hospital had electricity. A



wire was strung across the water and life became luxurious. We could now turn on one ice box, and thereby preserve some of the food we had saved. We could also use the electric fry pan, or roaster, or toaster, or coffee pot, but one after the other, not all together. We had our first hot meal of stew. It was delicious.

When we had time to rest we listened to the water lapping at the floor we were standing on, and the logs and debris bumping the walls as they floated by. Boats came to any door. We tried to be at the right one at the right time. Small helicopters landed on the 1906 wing roof at least once a day to see how we were faring, leave supplies, or to pick up someone or something. Really, there was plenty of activity, but not that usual to a busy hospital.

As soon as the water had receded about a foot lower than the sand bag dike, we began the process of pumping out the basement. This provided another duty. Every two hours the pump needed refueling.

With all communications severed, there was no way to reassure our relatives and friends. On Friday, near noon, Archbishop J. Ryan appeared at our door, having come up from Anchorage on the Governor's plane. We were so happy to see him. He carried our messages back with him on his return.

The persons in charge of the walkie-talkies manned them for long hours, and at times fell asleep at the job. The patience of the men at the control station was remarkable. Sometimes several minutes passed while tunes were whistled or sung before a response was heard. As the days passed however, the "Roger" took on a more impulsive note - "Roger! Roger!" and toward the end "Roger! Roger! Roger!"

We soon learned of the numbers of refugees on the College Campus, at Lathrop High School, Main School and others. We decided however to stay in the hospital to continue

distribution of the supplies that we had managed to rescue.

As the mucking out process continued, one of the workmen injured his back. We took him to the emergency room and called for a doctor. On arrival the doctor wanted medications to inject. We searched the entire hospital before finding a syringe, a needle and an ampoule of medication. Where do you find syringes when all you have saved has been given away? Many times we caught ourselves heading for the stairs to get something from the basement.

Fortunately the walls were solid and we pumped out with no difficulty. Of course all of our supplies were lost. Room after room was opened and the contents sent to the dump. We had always known that our basement was a service area but we never realized how much until it was taken from us. Naturally the boiler room is there and that is the heart of the hospital. It provides steam heat, steam for the kitchen and steam for the basement sterilizer room. The central supply department and the surgery pack rooms were completely flooded. The electrical panel was all under water. Two emergency generators that were dry could not be used as their wiring was through this same panel. The drug room, and drug storage, the main hospital storage, the freezer and all the food storage, and the hospital telephone equipment were all flooded and a total loss.

This flood was a tremendous experience. I am not sorry to have been a part of it. Everyone shared. If your home was spared, you took in so many friends and neighbors that it was your home no longer. People were kind, extremely kind, and the needy proud had to accept. The water treated everything alike, modern house and old shack. It had been your home and your treasures. Even where all was not washed away the water damage was severe, often total.

# FLOOD NEWS FROM FAIRBANKS

By Doris Southall, R.N.

On August 14, at 7 A.M., I was awakened by the ringing of the telephone. The call was from Mr. Ernest Presher, assistant superintendent of schools. He said, 'Mrs. Southall, will you report to Barnette School to help set up a shelter for the flood evacuees that are being flown in from Nenana? Also, will you contact Mrs. Delores Scholtes? Ask her if she will help at Barnette School and then set up a shelter at Denali School in case that building is needed?' Mr. Presher said he'd notify Mrs. Kay Ferguson to set up a shelter at Hunter School for the Island Homes people who were being evacuated at this time.

When Delores and I arrived at Barnette School, Mrs. Irene Brooks, R.N., chairman of the Red Cross Home Nursing, and a board member of the Fairbanks Red Cross Chapter, was already on duty. Mrs. Brooks has had a number of years experience doing disaster nursing. Present also, were several young people who had volunteered to help us. They were wonderful--we just don't know what we'd have done without them. By then, the Barnette cafeteria cooks were busy preparing food.

Supplies began to come in and we were all kept very busy moving furniture to make room for cribs, setting up cots, checking medications, and ordering emergency medications and other supplies for personal needs, necessary for taking care of several hundred people.

At this time, we were totally unaware that by the next morning the entire city of Fairbanks and many surrounding areas would be flooded and that the people would be coming to the shelters. Monday night the Lathrop High School was opened as another shelter.

Between 10:00 A.M. and 11:00 A.M., the people from Nenana began to arrive, weary from long hours of trying to save their homes. They brought with them only that which they

could carry. They were cheerful and cooperative, in spite of their not knowing if they would have homes to return to after the waters receded.

After lunch, Delores left for Denali School to prepare for the evacuees who were being taken there.

About 5:00 P.M., a friend was driving me to my apartment in the Northward Building for clothing. We discovered it was impossible to get out of the car on Noble Street or on Third Avenue without the aid of knee-high boots.

The drains had started to back up, flooding the area. I decided to forget about the extra clothing for the time being.

Later that evening, help arrived and I went to Denali to see Delores. At 9:30, we left to spend the night with a friend. This friend had no water around her home at 10:30 P.M.. However, a bit after midnight, we were awakened by a knock on the door and were told to leave at once. We scrambled into our clothing, grabbed the bedding and some food. Having no idea where to go, we started for Lathrop High School.

At this time, the homes near the river were beginning to flood, and the army trucks were bringing people from this area. These trucks, driving through the deep water, were causing waves such that we could not drive because the car was rocking back and forth. Not knowing how deep the water was, we decided to return to Cushman Street and park the car. On arriving there, we noticed a couple of men, one of whom had a radio. We called Civil Defense and asked them to send someone for us. While awaiting this transportation, the driver of a small gray truck offered to take us to Bassett Hospital at Fort Wainwright. The road to the base was already covered with water and there was much debris and many logs floating around



the truck. As the driver was most careful, we arrived without mishap.

On arriving at Bassett Hospital, we reported to the section housing the patients evacuated from St. Joseph's Hospital. As they had sufficient staff, we went to the nurses' home and listened to the reports on the transistor radio. We also watched the water slowly creeping in around the base. At 4:00 A.M., Delores commented on hearing water running into the basement. We looked and discovered the water already about six inches deep. Delores reported this fact to the hospital. Two army men checked and then asked us to alert the nurses as they would want to get their belongings out of the lockers. In a very few minutes, these nurses were carrying their personal belongings from the flooded basement.

Lt. Colonel Elizabeth Clark, Chief Nurse, asked us if we would like to go to bed and rest. It was indeed a welcome invitation. Little did we realize that it would be days until we would be back in our own beds.

At 9:00 A.M., we were pondering as to how we could get to Lathrop where our help was needed. We had been watching helicopters with patients from Fairbanks, landing in front of the nurses' home. We decided to ask for a ride. As one of the pilots, returning to Fairbanks, had no passengers, we asked if he would take us. He did. Several nurses from St. Joseph's Hospital were also in need of a lift back to town. The pilot offered to take them on his return trips.

Arriving at Lathrop High School shelter (later named the Lathrop-Hilton), we found several thousand evacuees, with more to come during the next few days. One would not recognize it as a school, as all school equipment had been pushed aside or piled in corners. People were sleeping or resting on the floor while others were milling about the halls.

We reported to the nurses' station and found Irene Brooks was already there, having set up an infirmary, nursery and an isolation

ward. Every nurse found plenty to be done as this was only the beginning. The shelter was needed for several weeks. Delores left Lathrop to report to Barnette and Denali Schools. She stayed at Denali until Friday, when that shelter was closed.

Public Health nurses began to arrive from all over the state to relieve our local nurses.

Sister Mary Elizabeth and Sister Mary Clare, P.B.V.M., from Anchorage, took charge of the infirmary. We appreciated their many hours of labor. They were so kind, helpful and understanding of the people's needs. Without them the task would have been impossible.

Over one thousand patients with major and minor ailments were seen by the doctors---not to mention the thousands of typhoid immunizations that were administered in the building.

The medical staff consisted of Drs. Weaver, Petajan, Lyons, Williams and Marrow; RN's Irene Brooks, Doris Southall, Ingrid Guling, Mary McKenzie, Judy Brooks, Shirley Pauliska, and Sandy Graham. Becky Curneen and Karen Wellesby, the two Public Health nurses, were from Anchorage. Some of the volunteers who helped were Vickie Paken, R.N., Peggy Hemmenkamp, Annetta Roth and Ellen Rambeck. Ellen took over the care of those in isolation. Orchids to her for the wonderful job she did.

Dr. Petajan, Becky Curneen, Karen Wellesby and I went by boat from Lathrop to the Northward Hotel to give typhoid immunizations to over three hundred people still living there. When we reached the building, we had to get into another boat and climb up a ladder which was fastened to the boat and to the building, then another ladder, up dark halls to the fifth floor where a clinic had been set up by Mrs. Harriet Morton. Mrs. Morton was formerly one of our school nurses who was here on a visit. She helped Dr. Arthur Schaible

with the medical needs in the Northward Building.

The return boat trip to Lathrop shelter was one that none of us will ever forget. We ducked under trees and bumped into a house, cars and the fire hall. We were very happy to change boats at the fire hall and to have a smooth trip the remaining distance.

Mrs. Vivian Johnson, supervisor of the cafeteria, and her staff, plus volunteers, served us two well-balanced meals a day, with a snack in the evening.

An enclosed area housed many dogs and cats of all sizes and breeds. They, also, were served food and water. And, if you can imagine it--not one good dog fight was witnessed!

The Lathrop shelter, one might say, was on

an island, but inside its four walls, over 3,500 people were living in 'Lathrop City'. We had police service, as well as taxi, boat and helicopter service, a sanitation office, movies, restaurant, a hospital and several hotels. No money exchanged hands.

What a relief it was to witness the arrival of Miss Jeanne Durr, R.N., National Red Cross Representative from Washington, D.C., and Miss Shirley Meyers, R.N., Western Area Representative from California, and the many other Red Cross nurses from all over the United States. They immediately took over the nursing responsibilities.

Credit cannot be given to any one person, as everyone showed true pioneer spirit and gave help when help was needed.

## FAIRBANKS FLOOD

*Identification of color pictures on center spread*

1. Chena River and the remains of 1st Avenue.
2. Island Homes Subdivision - verily.
3. Near downtown Fairbanks, as water receded.
4. Near College Road.
5. Kantishna Street, note the boat in drive-way.
6. Cowles Street as the water was receding.
7. 4th Avenue, note the water line on the brown building.
8. Downtown Fairbanks, near police station, marina or parking lot?
9. Cushman Street Bridge and aftermath debris.
10. Minnie Street and aftermath debris.
11. First Aid Station -- Doctor Bill James, at work.
12. Downtown Fairbanks from the Air.
  - A. Northward Building
  - B. Fairbanks Clinic
  - C. St. Joseph's Hospital
  - D. Polaris Building
  - E. Lacey Street



# THE FAIRBANKS FLOOD

## AS SEEN FROM ANCHORAGE

By Arndt von Hippel, M.D.

The Fairbanks Flood was a natural disaster of major proportion, but the citizen response to it was far more impressive. As brought out by the several flood articles in this issue, everyone shared and everyone who could, helped. Magnificent spirit and endurance was shown by the people of the Fairbanks region, both civilian and military, during the crisis; while the rapid postflood recovery has represented a phenomenal effort.

Interestingly enough, there was no real warning of the impending flood, and when it struck the initial rapid rise in water level made immediate escape the major problem in many parts of town. From all accounts the crowding and facilities during the worst week were unbelievably bad. While side by side cot accommodations in public waiting rooms were common, as at the airport, many families had to be pressured out of camping in totally inadequate facilities, such as a moist automobile, for example.

Some problems encountered were unusual. For example, with the sudden loss of their "pill", everyone who could, menstruated. And speedboats going along town streets and byways caused major breakage of expensive thermopane windows with the debris thrown up by their wake. Or the one hold-up reported that involved a getaway boat and an attic window. Looting apparently was not a major problem, possibly because of the military presence, possibly because of the high and muddy waters, or possibly because of the spirit of the people.

As reported elsewhere, rumors were the main source of (mis) information. The radio stations contented themselves largely with re-

porting local pickup and delivery problems and emergency requests, so that no information of area wide significance was available to the many people glued to their transistor radios.

The salvation of the Fairbanks area was air transportation, particularly the Air National Guard unit from Anchorage, as all area-wide ground transportation, including the railroad, was wiped out. With this in mind it is interesting to note that for several days the water level went above the taxiways but never quite reached the main airport runway. With only a slightly higher water level the runway could not have been used. As it was however, it was a lifeline, and the overworked Air National Guard carried the ball, and everything else.

After a few days, when the extent of flooding and the probable duration of population displacement became apparent, the Air National Guard was given the added task of relieving critical congestion by evacuating about one-third of the Fairbanks population. Anchorage was prepared when the 5000 refugees arrived, and the entire transfer went smoothly.

For days the various Anchorage based relief and disaster agencies, and others interested, had met and organized, and they had developed a plan which proved up well. Without fanfare and in a "business as usual" atmosphere, carloads of contributions of new clothing, food and essentials were rapidly collected; accurate lists were started and maintained of available housing, almost entirely in local homes; and evacuation centers were staffed at both the Kulis Air National











Guard Base and at the commercial terminal in Anchorage's International Airport.

Incoming evacuees were conducted between towering piles of paper diapers and mobile canteens dispensing free food to tables where they registered into their temporary homes. Although largely destitute, unavoidably dirty, often only partially clothed and generally without even a hand bag or luggage, and despite arrival at all hours, placement was rapid. Usually the entire plane load was registered into volunteer homes within 5-10 minutes of landing. Although various notices were posted of special accommodations available to certain fraternal, race, and religious groups, the generally followed placement procedure paid no attention to these artificial distinctions.

The often ill and confused evacuees being helped from the unpressurized Air Guard cargo planes were mostly women and children. They had embarked without any knowledge of what was available in Anchorage, knowing only that evacuation had been ordered, and most were very concerned about having no money for the hotel bill, or even for a phone call. They needn't have worried. The hotels had already been packed to overflowing for several days, as the flood jammed Anchorage with cancelled tours and displaced tourists. Even as the evacuation started, at least one major Anchorage hotel already had large groups of male and female tourists bedded in cots in different meeting rooms and service areas.

Many of the local homes volunteered were not needed. The citizen turnout to meet each plane and provide housing for evacuees was always larger than required by those on board and was most heartwarming. As the flood evacuation progressed, some of the civilian airlines were apparently permitted to issue tickets to be billed to the CAB, but because of various rumors suggesting that one would then have to buy a ticket to return, most

evacuees continued to come by the unpressurized and bumpy Air Guard cargo plane route. With a minimal altitude of 12,000 feet required en route to get past the Mt. McKinley area, many elderly persons and infants "passed out" in flight, some requiring resuscitation. This additional worry made the weary pilots try to stay as low as possible, which, of course, made it rougher yet. It should be easy to imagine the illness and misery on those flights.

To expedite evacuation, registration, and housing, and to avoid many unnecessary ambulance rides for all those who had "passed out" or become ill en route, Anchorage physicians provided 24 hour coverage at the emergency room at Kulis, for the duration of the evacuation. This service was much appreciated, although very little significant disease was encountered. In addition a number of private medical offices were kept open several evenings a week during the emergency to provide free medical care, particularly obstetric and pediatric. This medical effort was supplemented by several local pharmacies that stayed open after hours to provide free drugs and prescription refills. These drugs were given partly by the manufacturers, and partly by the local pharmacies. Generally however evacuees obtained their necessary medical care in private medical offices on a free or "insurance only" basis. This was done spontaneously and without organization or preplanning.

The Red Cross and Salvation Army did a magnificent supporting job, with Red Cross later providing emergency clothing and food kits to evacuees. These took some of the financial pressure off the many local hosts caring for their "unexpected guests". Local newspapers published the extensive lists of names and addresses of evacuees. There really was no confusion in this major logistic triumph.

After some days the major phone trunk



lines were placed back in service and separated families were then able to communicate. Finally the railroad tracks emerged and were repaired, and the citizens of Fairbanks returned on the scenic, federally owned, Alaska Railroad, to proceed with the "mucking out" operations. Within another three short weeks, recovery work had proceeded so well that, except for a large number of space heaters in buildings, and much torn up tile flooring (that had separated in the flood) and of course the water marks on the trees all through town, the area looked relatively normal to the casual observer. Most stores went back into normal operation rapidly. Generally the clean up and repair work was done by the individuals directly concerned. Many latent skills were uncovered. If you wanted heat, you fixed your own furnace, as the repairman was too busy shoveling out his own house to repair all the furnaces in town.

The public portion of the recovery - the repair of roads, sewers, and utilities, was rapid, and was expedited by an influx of men and money. The hospital was very slow in getting back into complete operation, and for many weeks seriously ill patients were evacuated to Bassett Army Hospital and then to Anchorage for care. Despite the failure of all utilities and supporting services during the crisis, the continued and efficient operation of Bassett Army Hospital by Colonel Hardy and his staff was exemplary.

That St. Joseph's Hospital reopened at all was a surprise to many, as this could have been an excuse for the Sisters to proceed with closing plans previously announced. At some expense however, they did reopen their hospital, while announcing again a definite termination date beyond which they would not run the present antiquated and crowded structure. (See Muktuk Morsels).

Most of the major losses sustained represented a lifetime of hard work. Very little except the loss in automobiles submerged was

insured. The insurance companies generally "totalled out" any submerged vehicle and then permitted the owner to purchase it back at less than half price. (Recently one auto dealer has been indicted for allegedly trying to sell flood damaged vehicles fraudulently.)

Although there was some jockeying for position among the various overlapping and often competing Federal and State Big Wheels, none of this was really too important. The real hero was the Alaskan, who lost his shirt but not his neighbors and friends; and who then dug in and worked like hell to regain a little of the lost ground. Surprisingly, not many left Fairbanks permanently, and in these cases the Flood generally expedited but did not cause the departure.

One lesson was again taught by this flood. It was painfully obvious to all concerned that adequate communication was essential for any coordinated planning or activities. And communication was totally inadequate. In this modern age of satellites that at many million miles away can take dictation and send messages, the only way to find out what was going on across town was to go there. Communication was on the mouth to ear level. Even smoke signals might have helped.

The one or more radio stations that struggled back on the air apparently made little effort to assess or coordinate area problems, and restricted themselves to a general broadcast of emergency messages, many inaccurate, many just rumors, many resulting in much unnecessary duplication of rescue effort, and none of any use to the many inhabitants of attics and waiting rooms. These citizens got their only estimate of how things were going from the change in water level on the front of the house, or from who or what was floating by. For example, attempts over several days by the Anchorage Civil Defense Office, to explain and to expedite the evacuation, were relayed to Fairbanks by ham radio, but not a word was heard over the radio sta-

tion, except more about local requests for assistance. Meanwhile rumor fed rumors and many people living in misery didn't know of or didn't dare to be evacuated, for fear of impossible expenses, or getting lost, or what have you.

In general then things needn't have been so bad, and those in charge should have done what any good revolutionary does, seize the radio station first to tell the public the important news and permit coordination of effort. If a radio station is operated as a public facility at the pleasure of and for the service of the people, then it would seem reasonable to require all radio stations to have an emergency power supply, and to maintain effective ham radio equipment for use in a public emergency. This would not add greatly to the cost of owning and operating such a station, as the know-how is already there, and it would certainly increase public comfort and safety. Also authority should be granted, to civil defense personnel, to take over any local radio station in any local emergency when necessary; and to require clearance for any disaster information to be broadcast by the often inane as well as inaccurate disc jockeys. At present such authority only exists in a nationwide emergency.

Ideally a separate two-way radio communication system should also be available, on a common emergency wave length, to permit all interested parties to coordinate rescue and relief activities, determine needs and arrange meetings for major decisions. This has been done in other areas where inexpensive modification and purchase of two-way radios has permitted the police, civil defense, fire, ambulance, medical and military departments to better and more directly coordinate emergency activities, even when phone systems are working. All two-way radios in government vehicles should be required to have this emergency capability.

Lastly, it is interesting but not particularly heartening to realize the extent to which each Federal and State Department has become a kingdom, with its own hierarchy and emergency plans. Many of these not only do not relate to those of other departments, but may be directly in opposition. Although this apparently was not a major problem in Fairbanks where in fact all involved generally performed well, it is very noticable in the Anchorage area where we can still encounter brand-new department level plans, directing community wide responses to various disaster possibilities, that are not only unknown except to some coordinator and his staff, but often unrealistic and thus ineffective.





# THE FIRST SPECIAL SESSION- FIFTH LEGISLATURE

## Or the New Speak

September 29-October 4, 1967

By Milo H. Fritz, M.D.

In the middle of August in 1967 a devastating flood struck the city of Fairbanks. When the waters receded, the roads, all the utilities and over 90% of the private dwellings and business establishments had been either slightly or severely damaged by the waters and in many instances, destroyed entirely.

With the advancing season and the imminence of winter with its temperatures ranging from 40° to sometimes 60° below zero, the problem of restoring utilities and the habitability of homes became acute. The problem resolved itself into whether or not efforts should be made at making the city able to withstand the rigors of winter and the unknown influence of the spring break-up, or abandoning it altogether as being too far gone for restoration. Considerations of humanity as well as finances dictated the need for extraordinary and prompt action. To this end, Governor Walter J. Hickel called a Special Session of the Legislature, the sole purpose of which was the enactment of legislation that would allow and encourage the citizens and business establishments of Fairbanks to muck out, restore and continue their lives in Fairbanks and the Golden North Borough, as nearly as possible as had been done before.

In the olden days we used to speak of making up deficits in estimated income. Also, up until recent times, short falls represented a tumble of minor severity, let us say off the

bottom step or off the curb. But today, when employing the new speak, these two words are united into one, resulting in the horrible word "shortfalls" which indeed means deficits. This word was used throughout the Legislature and I suppose, is now as much a part of the language as the word ain't and just as wrong.

Following the Legislative Session there were a couple of legislators, after celebrating the adjournment at 2:30 o'clock in the morning, who had a few shortfalls of their own on the way to their hotels for a few hours sleep before the planes left for their homes.

A completely thought out and well developed package of legislation had been prepared by Governor Hickel and other members of the Executive branch and was ready and waiting for us when we assembled on Friday, the 29th of September at 10 a.m.

The weather was particularly lovely and the people of Juneau did everything they could to make us welcome. The hotels and motels gave us special rates. I stayed at a new little place called the Breakwater Motel and had a very handsomely furnished room overlooking the small boat harbor where at times I could keep an eye on the small boats and planes that went back and forth on this convenient route.

The construction of the building, however, owing to excessively high labor costs was of the usual flimsy type that makes every foot-

fall shake the building and makes the most intimate sounds audible in the next or sometimes two rooms away from my own.

The location was particularly suitable in that it provided a one mile walk between the Capitol and my room. Doing this three or four times a day made it possible to overcome, to some extent, the vitiating effect of the smoke filled rooms, too much food and no exercise.

Instead of all standing committees meeting separately, the Finance Committees of both Houses met with the committees such as, Local Government, State Affairs, Health, Education and Welfare and other that were concerned with the various bills as they were prepared for submission to the respective Houses. Ordinarily they consider the bills separately.

Testimony came, for the most part, for the delegation of government officials from the Golden North Borough and the city of Fairbanks. These men all were extremely tired and haggard not only from developing evidence substantiating their needs but also from the strain of the flood itself, destruction of their own property and undoubtedly the distraction caused by having to leave their families back there preparing for a relentlessly approaching severe winter.

We had, for evidence and planning for the proper disbursement of funds and their control, the Commissioners of Administration, Highways, Commerce and many others.

The participation of the federal government through the Small Business Administration, the Federal Housing Administration, the Office of Emergency Planning and others were carefully inquired into by the Legislators. Federal and state projects were integrated in such a way that the vast job of making Fairbanks self-sustaining through the winter, with an active economy to make jobs available and keep businesses open, was carefully considered. If the people abandoned

their businesses and homes because of the sheer magnitude of the problem of restoration the effect would have been disastrous and could have resulted in the virtual disappearance of the city of Fairbanks.

Due recognition was taken of the extraordinary efforts of the President of the United States, officials of the Alaska Railroad, the Salvation Army, the Red Cross and others in declaring the Tanana Valley a national disaster area, thus making funds available that otherwise would have been unavailable.

In the House, Chairman Harold Strandberg of Anchorage worked with his committee 16 to 20 hours daily, making certain that everything was done in the proper way and scrutinizing the expenditure of all funds. Commissioners of the State as well as federal officials were available around the clock for testimony, sometimes for the solution of a problem that took five minutes to clarify to discussions that sometimes went on for as long as three or four hours.

Measures were taken for the relief of people who lost their homes completely, who lost them in part or who suffered severe damage to the furnishings. Relief was provided for people who were without work because of flood damage by extending unemployment security payments 50%. Various kinds of debts were forgiven, the time for repayment of loans extended, energetic repair activities encouraged by the various financial means, all of which were given definite termination dates in 1968.

The frightful havoc wrought on the roads, telephone and other utilities were given careful study, and means provided through which they could be back in full operation as soon as possible. The great majority of the Legislators as well as those in other branches of the government and I hope those who read this, are particularly proud of the system that we used of not only providing for the expenditure of funds but also for providing, through



taxation, means of replacing them in the state general fund. We imposed a tax on each individual who works in the state along with his school tax, amounting to \$10.00, to be terminated as soon as the cost of restoring Fairbanks has been completed. The tax is to continue until a sum of \$7,500,000 has been accumulated in reserve funds against future disasters.

A 1% severance tax was placed on the oil industry. It was somewhat controversial. Officials of the oil industry had been contacted by phone by the Governor and his staff. While not exactly enthusiastic about being taxed before their operations in Alaska reached the profit making level, they nevertheless raised no audible objections during the time that we were in session and testimony invited. There was, naturally, much opposition to the imposition of both taxes but with the clear establishment of termination dates and the amount of money to be collected, most of this opposition died.

Special powers were granted the Governor and a special fund placed at his disposal, for preventive action as in the case of the threatening flood in Skagway where several hundreds of thousands, if not millions of dollars had been saved by prompt action. A further fund was provided for the Governor's use in state disasters and federal disasters as declared by the President of the United States.

We were there five days and these days began at eight in the morning and ended at midnight. We finally adjourned at 2:30 a.m. of the day that I came home, Wednesday, October 4th.

Naturally we made use of federal funds

available through the taxation that affects us all. But we did not irresponsibly spend money without providing a source for restoration. We did not go crying to Uncle Sam for money that we could supply ourselves through the medium of taxation.

Of course those on any kind of relief or old age assistance, or blind or similar assistance programs were exempt from the employment tax of \$10.00.

There was no objection on the part of labor to either tax except that there were some indications that labor would have liked to have imposed a greater tax on the oil industry.

The feeling seems to prevail that we simply had to do something for the poor people of Fairbanks before the iron cold of winter took hold, making certain aspects of work impossible until summer arrived once more. The possibility of high water with the break up in May or June was also considered. Thus might further cause damage as yet unsuspected and undeterminable, because no one can tell just how much flooding the annual spring break up will cause and how much hidden damage the recent flood has caused.

In the Fairbanks area, the \$5,500,000 hospital bond issue was defeated locally. We had made available a means of backing up such a bond sale because Fairbanks badly needs a new hospital. Since the local option of bond sale failed, \$400,000 will be saved by the state.

I deeply and sincerely hope that the actions of the Governor and his staff and the Legislature, including its three physician members are pleasing to you and worthy of our form of government which is the envy of the world.

# MUKTUK MORSELS

## FAIRBANKS

In a referendum conducted after the Fairbanks Flood the voters of Fairbanks again turned down a hospital bond issue. As a result they lost a special state disaster contribution to a new hospital which was contingent upon passage of the local bond issue. The town is now on definite notice by the Sisters that they will close St. Joseph's Hospital next summer. Obviously a town of this size and isolation needs a hospital. In addition it would seem unreasonable to expect the growing number of well trained physicians in Fairbanks to remain there, in the absence of such a facility.

A possible solution would be for the military to open part of the relatively enormous Bassett Army Hospital for the use of civilian patients and their physicians. Possibly this was one facet of a recent proposal to the Presidents Review Committee for Development Planning in Alaska by Dr. Joseph English, head of the O.E.O. Office of Health Affairs. With the support of Sargent Shriver and Hubert Humphrey he made a cabinet level proposal that all Federal medical resources be mobilized to eradicate disease among Alaska's poor. The proposal "would open all federal hospitals in Alaska, including those of the Army and Air Force, to persons requiring treatment and lacking funds to pay for it". This delightfully simple stroke for a better tomorrow does raise certain questions however.

1. Who are the "poor" herein referred to? If the recently developed concept of medical indigency" (anyone who cannot afford a catastrophic illness) is to be used, possibly physicians should support this plan, as it will obviously cover them as well.

2. Would the presently clogged Native Hospital medical care facilities also be opened

to the "poor" whites and negroes, most of whom have jobs and some medical insurance? And would this result in better medical care for the "poor natives"?

3. Would the present system of fee-for-service care of the welfare patient by the private physician then be replaced by a federal physician providing care in a federal hospital?

4. Would the present medical staffs be able to handle the excess patients brought into Elmendorf and Bassett Hospitals? Or would not more physicians need to be drafted to handle the load.

5. Would not a major transfer of the patient load from their present private physicians lead to an unnecessary duplication of facilities. It might seem wisest in this case to draft the private physicians of Alaska so that they could continue to serve their former patients (with better working hours).

6. Possibly then the few doctors left in private practice should put up notices "practice limited to the very wealthy" to avoid competition with federal facilities.

7. Could not the Salvation Army stop giving out free Thanksgiving and Christmas dinners if this all came about? After all if the experience of the V. A. Hospitals is any example, one could expect entire families of the "poor" to check into the hospital for the holidays, or possibly even for the winter. If a certificate of illness were required, undoubtedly they could get this from their Senator or Congressman. The proposal certainly is interesting.

When the Mayo Cardiac Team visited Fairbanks this year, one short month after the peak of the flood, they were impressed by the normal appearance of the recently submerged community. Sponsored as usual by the Alaska Heart Association, their visit to Fairbanks



was limited to one day by the lack of accommodations for out-of-town patients.

Drs. Ritter, Connolly and Kincaid saw 21 patients in consultation in Fairbanks and delivered two excellent clinical lectures. In Anchorage they joined Dr. Weidman and held an excellent 3 day session of lectures and consultations, seeing 131 patients for private and native hospital physicians. They then went on to Sitka-Mt. Edgecumbe to complete their clinical tour. As yet we have no report on the number of patients seen there. On this very successful clinical tour they again dealt with many interesting cardiac problems, as well as several huge trout.

We are impressed by the fact that no physician in private practice has left Fairbanks since the flood. This is despite major financial loss by almost the entire medical community.

Dr. Paul Stuck is back from Harlan, Kentucky, and will be practicing obstetrics and gynecology in association with Dr. Henry Storrs. Dr. Lionel Richardson has resigned from the Northern Regional Health Office and moved to New York.

#### TOK

Dr. Harvey Snyder tried to establish a general practice office and clinic here this summer, but found it impractical and has returned to Ohio.

#### EAGLE RIVER

Dr. Thomas F. Green has opened his offices for general practice in Eagle River.

#### SOLDOTNA

Completion of the Peninsula General Hospital is now in question as future loans by the SBA have been refused. With several hundred thousand dollars still needed, this

project, which has the support of the Anchorage Medical Society, needs all the help it can get. It is obviously essential to complete this facility but the question now is "How"?

#### ANCHORAGE

Dr. James Coin, a board certified radiologist, has returned to Anchorage and joined the Doctors Clinic and Anchorage Community Hospital as staff radiologist.

Dr. David Dietz of Rochester, N.Y., has joined the Doctors Clinic. He is board certified in general surgery and board qualified in thoracic surgery.

Dr. Thomas Harrison of Portland, a board qualified ophthalmologist, has opened a private office in ophthalmology.

Dr. Barbara Ure of Minnesota, who is board certified in psychiatry and child psychiatry, has resigned as director of Children's Services at A.P.I. and has opened a private office for the practice of child and adult psychiatry.

Dr. Ernest Pretz has taken a prolonged leave of absence from the Anchorage Clinic and returned to Texas after four years of general practice in Clear and Anchorage.

Dr. L. David Ekvall and Dr. Michael Hein recently attended the American College of Surgeons meeting to receive their F.A.C.S.

Dr. Theodore Shohl got his private pilot's license.

Dr. Ken Fleshman passed his pediatric boards.

Dr. Marianne von Hippel passed her pediatric boards.

Dr. W. J. Chapman, Commissioner of Health and Welfare, addressed a joint meeting of the Anchorage Medical and Dental Societies on November 21. He discussed the current status of Title XIX (Medicaid) and P.L. 89-749 (Comprehensive Health Planning) and the rapidly changing Federal - State relationships in the Health and Welfare fields.

He mentioned a number of recent appointments to the Department of Health and Welfare including Mr. Ed Glotfelty as Assistant Comprehensive Health Planner; Mr. Glen M. Wilcox in the new office of Alcoholism; Mr. Stanley Harris, the new Director of Welfare; Mr. Joseph Betit, Administrative Assistant to Dr. Chapman; Mr. Howard Leach, Superintendent of the McLaughlin School for Delinquents Mr. Michael Malone as Supervisor of the Adult Assistance program; Dr. Grace Thompson as Northern Regional Health Officer in Fairbanks; Dr. Pauline Anderson who will be in Fairbanks in the spring as psychiatrist with the Department of Health, and Mrs. Henrietta Gillinwater, as the new Supervisor of Child Welfare.

Dr. Chapman emphasized that the policy of the Division of Welfare is to encourage self-sufficiency rather than perpetuate the dole, and we hope to hear more on this. He also stated that contracts with non-Alaskan specialists by the Department of Health have not been renewed, because of representation of all major medical specialties by the present physician population of the State. He mentioned plans to bring Medical-Dental teams to 58 villages under the "Headstart" program, and asked the private physicians and dentists of Alaska to staff such teams on a fee-for-service basis. Generally he indicated that, in time, the fragmented health and assistance programs to various cultural, ethnic and other subgroups would all be administered under the State Comprehensive Health Program.

In the discussion period following, some dissatisfaction was voiced by physicians and dentists present on the makeup of the Health and Welfare Advisory Council. As required by federal law a majority of the Council, (in this case thirteen of twenty-four members) must be "consumers" of health care (not associated with the provision of health services). This means that physicians, dentists, nurses and so on could be represented on up to twelve

seats. In the present council as appointed there is only one physician (Dr. Robert Wilkins) in addition to Dr. Chapman, and there is no dental representation at all. However various organizations dispensing health services are represented. One example known to me is Mr. Larry Sullivan, executive secretary of the Alaskan Tuberculosis and Respiratory Disease Association.

## JUNEAU

Dr. Robert E. Stelle has joined Dr. John Dalton as an associate in general practice at the Whitehead Clinic. Dr. Robert Cavitt has resigned from his position as Acting Director of the Division of Public Health to devote his full time to private practice.

Dr. Ralph Williams (Ph.D.), presently Chief of The Community Health Division, has been appointed the Acting Director of Health pending appointment of a permanent director.

Dr. D. V. Reddy has resigned as Director of Maternal and Child Health to take a similar job in Hawaii, in order to permit his wife to complete her residency training.

Dr. Grace Fields recently attended the American Heart Association Meeting as one of the two Alaskan Delegates, (with Dr. A. von Hippel).

## SAN FRANCISCO

A surprise resolution by the Alaska Delegation at the annual American Heart Association meeting, to "prohibit cigarette smoking at all official Heart Association meetings and offices", was passed amid considerable tumult and over the loud objections of those delegates so addicted. The "second" to this resolution by Dr. Eldon Ellis of California, who decried "speaking out of one side of our mouths while smoking out of the other", helped carry the day. Although only a resolution, it was nationally publicized, and should cause a number of nicotine fits.



# ALASKA'S ADOPTION LAWS

By Stanley Howitt

Alaska's present adoption laws were originally enacted in 1947, during territorial days. They have been amended from time to time, but the basic legal practice has not been changed.

This article reviews the purpose of the adoption law, outlines the existing law, and evaluates some of the primary areas which may be the subject of possible revision.

## Purpose of the Adoption Law

An adoption establishes the relationship of parent and child between persons who were not so related by nature. A new family unit is set up by statutory authority. The procedures set forth in the statutes must be followed explicitly.

The adoption law is designed to protect the child to be adopted. The state is concerned with his welfare alone and the adoption is to be in his best interest alone. It is the adoptive couple or person who seeks a child to adopt.



*Stanley Howitt*

It is the adoptive couple who has the burden of proof to establish that they are "fit and proper" persons to gain the custody of a child. The legal words, "fit and proper" are to be proved by the presentation of facts before the court to support them as a conclusion. Under our laws, it is the court that has the primary responsibility to adjudicate the fitness and propriety of an adoption.

To adjudicate whether or not an adoption shall be permitted, the court's inquiry must be thorough and its investigation complete, because:

"It is not enough that the adopting parents are willing to assume the obligations to the child imposed by the adoption statute and that the natural parents are willing that the child be adopted by the petitioner. It will be presumed that the court did act for the best interests of the child. Proof of the moral character and ability of the petitioner is usually required, but the welfare of the child may be affected by many other considerations, such as the age, intelligence, health and temperament of the petitioners, and the age, sex, temperament, and other qualities of the child." 2 Am Jur 2d. Adoptions Sec. 2

In many states, the court would have available to it the investigative report of a public welfare agency, that would be delegated under statute, the responsibility of child placement adoptions. The adoptive parents would have been screened by this agency even before the court had jurisdiction over the proceeding.

But in Alaska, there need not be the intervention of a public welfare agency or private adoption agency, and an independent placement, that is, a placement arranged privately between the natural parent and adoptive couple may be brought before the

court directly for adjudication. Of course, in cases in which the Division of Public Welfare, Department of Health and Welfare has secured custody of a child, an adoptive couple seeking such a child will be screened by the public welfare agency before the petition for adoption is filed in the court.

However, the vast majority of adoptions in Alaska at the present time are arranged privately. In 1966, out of a total of 552 adoptions in the State, only 113 were arranged through the public welfare agency. (Figures supplied by the Bureau of Vital Statistics).

Many would find this avoidance of an agency that is specially trained to handle the social problems of adoptions and which is designed to protect the child, a situation that would be in need of immediate legislation. But others, many with actual knowledge of the situation, might feel that our state has presently an efficient and swift adoption law that works reasonably well, without the services of a public welfare agency.

The answer as to who was right would be fairly difficult to ascertain. To this writer's knowledge, no records have been kept to indicate the number of independent placements that have been unsuccessful because the adoptive couple was not first screened and matched to the child that they were adopting. In writing to the Child Welfare Consultant for Adoption, Miss Jane L. Warner, the response to the above inquiry was:

"Although I am not aware of specific instances of problems concerning private placements occurring during my several months as Adoption Consultant, it is my understanding that certain problems have arisen in the past. One source of difficulty has been the private placement of children born in other states with Alaskan couples. The lack of initial screening by an Alaskan agency, coupled with the absence of any support or assistance from a caseworker during the adjustment period, has contributed to serious problems in the

child's later development. I cannot cite specific cases, but I understand that occasionally this Department has later assumed custody of the child." (Letter from Miss Warner to the writer, dated Nov. 14, 1967).

Before any change in the law could be contemplated to eliminate independent placements, figures should be obtained to substantiate the change. Matched to these figures must be those which would indicate the agency placements that have been unsuccessful. The matter of independent placements represents the key disputed area in our law of adoption. It separates our law from that of model legislation. There are many ramifications to having a strictly agency placement of all children to be adopted and this will be discussed as the model legislation is compared with our law. This legislation is the recommendation of the Children's Bureau, Social Security Administration, U. S. Department of Health, Education and Welfare and various conferences on adoption such as that held by the 1955 National Conference on Adoption.

#### The court's place in adoption

The entire adoption proceedings are under the jurisdiction of the Alaska Superior Court, whether the adoption be by way of private placement or public welfare agency placement. It is not the public welfare agency that makes the determination to reject or permit an adoption, but the court. This fact should be kept in mind as we review the proceedings.

#### The Adoption Proceeding

##### 1. Filing the Petition of Adoption

An adoption proceeding starts with the filing of the petition of adoption in the Alaska Superior Court. The petitioners, who may be an adoptive couple or a single person, need not be residents of the State.



The petition alleges facts to show that the petitioners are fit and proper persons to take custody of the child. It also sets forth the name of the person exercising actual care and custody of the child and further states that such person is willing to relinquish custody.

Proper consents to the adoption are necessary in order for the court to acquire jurisdiction, that is, have the power to terminate the natural parents' relationship and to invest that relationship with the adoptive couple. Under Alaska Statute, Section 20.10.020, consents are necessary:

1. From a minor 14 years or older who is to be adopted. Model legislation would make this age 12 years or older. (This change would reflect possibly the lowering of the age of maturity of the child to understand a situation which concerns him vitally).

2. From the parents of a legitimate child who is a minor. A minor is considered a child under the age of nineteen. However, consent is not necessary if the parent was divorced and not awarded full or part-time custody. This provision has been upheld as constitutional under a Alaska territorial case (Hammer v. Hammer, 16 Alaska 203 (U. S. Dist. Alaska 1956)).

3. From a mother for the adoption of a minor of illegitimate birth who was not subsequently legitimized. Model legislation provides that if the mother is herself a minor, the adoption must be concurred in by her parents or guardian.

4. From the Commissioner of Health and Welfare, if the Department has custody of the child, ie., the child is an orphan or abandoned.

Under Alaska Statute, Section 20.10.040, no consent need be obtained from the natural parents of a child to be adopted if:

1. A parent is insane for more than one year prior to the filing of the petition.

2. The parent has been imprisoned in a penitentiary for a term of three years or more at the time of filing the petition.

3. The parent has wilfully abandoned the child and this has been judicially adjudicated.

4. The parent has wilfully abandoned the child for not less than thirty days preceding the filing of the petition. The abandonment may be shown in the proceedings. Model legislation assumes that parental rights have been terminated before an adoption proceeding is commenced

5. The parent was divorced and not awarded full or part-time custody. However, he will receive notice of the proceeding.

6. The parent has been adjudged unfit to have care and custody of the child. But he too shall be given notice of the proceedings.

7. The parent is the natural father of a minor of illegitimate birth. No notice need be given him of the proceedings.

## 2. The Hearing on the Petition

The petition for adoption is heard not less than thirty days after its filing. Thus, an adoption can take place in a comparatively short time. There are provisions for personal service of natural parents as indicated previously, and of interested persons. If personal service cannot be made and the court believes that the petitioner did so attempt service, then a certified copy of the notice of proceedings is sent to the persons. Proper notification is also a jurisdictional requirement.

The adoption hearing is usually heard in the Third Judicial District at Anchorage and in the Fourth Judicial District in Fairbanks by the Probate Master. He might also be designated the standing master, which means that he is a person of professional ability who is appointed by the presiding judge of the judicial district to hear these cases and report on them to the Superior Court. It should be noted that reference to the Probate Master is by order of the presiding judge of the Superior Court. His appointment to hear adoption cases is

made pursuant to court rules and not by mandate of a statute (see Civil Rule 53, Rules of Civil Procedure). There are no full time masters in the First Judicial District (Juneau-Ketchikan-Sitka) or Second Judicial District (Nome). The judges of the Superior Court in these districts hear the adoption proceeding.

In 1966, there were 552 adoptions in Alaska (Bureau of Vital Statistics). The breakdown by city was:

<u>City</u>	<u>Number of Adoptions</u> (total)	<u>Agency cases</u> (Div. of Public Welfare)
Juneau	32	9
Ketchikan	19	10
Anchorage	378	63
Fairbanks	114	28
Nome	9	3

The actual number of adoption hearings might be slightly higher than that shown above, since it is assumed that not all adoptions heard were granted.

The reference to a master in the Third and Fourth Judicial District by the Superior Court may be attributed to the heavy caseload in other areas of the law. Also, it was the practice during territorial days to have the probate master hear the cases. However, it is possible that a change may occur in the Third Judicial District with the formation of a family court, and adoptions might be heard directly by the judge in the first instance. Rule 37 (b), Rules of Administration, which sets up the family court states that the court shall have jurisdiction over, "...all juvenile and contested domestic relation matters and a nominal workload of other matters related to the family."

The adoption hearing is not public and attendance by persons not involved in the proceedings may only be gained by court permission. Hard and fast rules of evidence are relaxed in the proceeding. These pro-

visions of Alaska Statute, Section 20.10.090 are in accord with model legislation.

The petitioners have alleged that they are fit and proper persons to adopt the child. The master or judge will thus take testimony, that is, gather the facts, to support or reject this conclusion. The adoptive couple will be questioned as to their home environment, marriage, financial abilities, religion, health, other children and any other pertinent data. The child's background will similarly be explored. The court has the inherent power, if in doubt at the time of the hearing, to request the Department of Health and Welfare to make a social study of the home environment or other matters. No doubt any other accredited agency could also be called upon to make the study. However, as a matter of practice, few cases have arisen to prompt the court to ask for a study in independent placement adoptions. But it is important to note that the power of the court to do so is there. Of course, in the case of a child under the custody of the Department of Health and Welfare, there is a social study report made to the court as a matter of course and there has been preplacement screening. The social study report will contain the basic material stated above, but in addition, a caseworker would have conducted interviews of both prospective parents, visited the home, discussed matters of adjustment, etc. The caseworker then becomes a witness in the proceeding. He is now an advisor to the court.

Model legislation, which assumes that there would be no independent placements, requires a preplacement interview and report, a trial period of living together, a final social study report, and that all children placed for adoption be under the custody of the public welfare agency.

Adoption hearings may be on the record, that is, the entire hearing will be taped and preserved, if requested by a party involved. It is also the practice of the master to record



any contested adoptions. Practice may vary from jurisdiction to jurisdiction. But records are necessary in order to appeal to the court if the decision is adverse to a party. Model legislation provides that all adoption hearings be on the record so that there would not be any necessity to have a new trial. By usually having a record in contested matters, this provision is partially complied with in the state. However, the better practice would be for all adoption proceedings to be on record.

### 3. Decision

If the judge denies a petition of adoption, appeal would normally be to the appeal court of the state, the Supreme Court. However, if the proceeding is heard by a master, and he rejects the petition, the petitioner may move the superior court judge to set the decision aside and grant the petition. A hearing on the motion is then held before the court. This is not a new trial because the hearing held before the master is inquired into on the record, and the petitioner argues why the master's decision should be reversed. However, the superior court judge does have the power to request additional information in such a situation. He might also turn the case back to the master for further hearing. Should the master's decision be upheld, the petitioner can then appeal to the Supreme Court. The master's decision can also be overturned since the superior court judge has wide latitude in an adoption proceeding. The recent case of Hickey v. Bell, 391 P. 2d 447 (Alaska 1964) has reaffirmed this power of the court.

### 4. Decree

The adoption decree becomes final six months after the order is signed. It should be noted that a 1966 amendment to the law requires that a child must be within the jurisdiction of the court in order for an adoption

decree to be signed (Alaska Statute, Section 20.10.100).

Model legislation differs considerably with regard to the finality of a decree and also to the interim period before one can be signed. Our law, as previously stated, permits an adoption hearing not less than thirty days after the filing of a petition. The model legislation provides for the hearing twelve months after the filing of the petition and placement of the child with the adoptive couple during this period. Since a public welfare child placement agency is contemplated, the child's placement during the twelve months is supervised by the agency. The home adjustment of the child is observed, etc. After the adoption decree is signed, it does not become final until two years thereafter. By finality is meant that any irregularity in the proceeding or the proceeding itself cannot be attacked by anyone, with the possible exception of fraud.

### 5. Legal Results

The decree of adoption terminates the relationship of the natural parents, other than the spouse of an adopter, to the child. The natural parents are divested of all legal rights and obligations with respect to the child. The child in turn, is free from all legal obligation of obedience in respect to the natural parents. He is now the child, legal heir and lawful issue of his adopter, having the right of inheritance and the right to take testamentary disposition. He is also subject to all the usual obligations in turn. The adopter may inherit from him, as specified in the statutes of descent and distribution (Alaska Statute, Section 20.10.120). These provisions are similar to model legislation.

### 6. Records

Adoption proceeding records are confidential and are not open to any person except from

order of the court. Provisions relating to records, such as the filing of the new birth certificate, are found under Alaska Statute 18.50.210 and 20.10.130.

#### FURTHER ANALYSIS OF TYPES OF ADOPTION IN THE STATE - RELATIVE OR NON-RELATIVE ADOPTIONS

We have cited the fact that in 1966, there were 552 adoptions in the State, of which 113 were public welfare agency cases. A further breakdown discloses the number of relative and non-relative adoptions. These figures are important because as a general rule the court will tend to be more liberal, and its job is made easier, when a family relationship of some sort existed between one or both of the adoptive couple and the child before the adoption. Model legislation even permits the waiving of a trial period of placement in such cases. According to the 1966 adoption summary of the Bureau of Vital Statistics, of the 552 adoptions granted, 242 were to one step-parent. This would usually mean that one natural parent was the other half of the adoptive couple. Of this total, 11 were agency cases. Non-relative adoptions by an adoptive couple totalled 307. Of this total, 102 were public welfare agency cases. One non-relative person was allowed to adopt a child. To round out our total figure, two step-parents and their spouses were permitted adoptions. Possibly no natural parent relationship existed in these cases.

Thus, the actual number of non-relative adoptions granted in 1966 which were independent placements totalled 206.

There were 260 illegitimate children adopted with 84 being agency cases. Thus a possible 156 illegitimate children were adopted, possibly by independent placement and by non-relatives.

The Superior Court therefore had to adjudicate 206 independent non-relative adoptions

throughout the entire state in 1966. The number of such adoptions is no doubt small in comparison with other states.

The writer has no figures on the number of these adoptions that were arranged with the aid of professional or other persons, ie., doctors, lawyers, priests, etc. By "aid" is meant the actual act of being an intermediary in the adoption, either from the standpoint of introducing the parties to each other or else counseling.

The extent or non-extent of a problem lies with these figures.

#### RECOMMENDATIONS

Independent Placements - The general trend in adoption law is to turn over to the state public welfare agency or to a licensed private agency, the entire job of child placement. Implied in this task is the counseling of the natural parents and future parents, investigations before and during placement. The public welfare agency assumes custody of each and every child to be placed for adoption, usually terminating parental rights before the adoption can take place. The agency is the principal advisor to the Court. Some writers see in this the abdication of the court in actually adjudicating the adoption, since in their opinion it is merely rubber stamping the agency's decision.

Public welfare agencies have been criticized in their handling of adoptions because they have often formulated ill-conceived and totally unrealistic regulations governing adoptions. They may amount to nothing more than a bundle of red tape ending up by hindering adoptions by qualified persons.

On the other hand, many states have actually prohibited independent adoptions and made them illegal (ie., New Jersey). The legislation is principally an outgrowth of a belief that corrupt practices result from such adoptions. Intermediaries can arrange adop-



tions for personal gain, without consideration of the welfare of the child. Black market baby operations have been known to occur in some states.

But the basic reason for such legislation may be that it is thought that a public welfare agency is a professional organization that is designed to best handle such matters as adoptions. Other professionals are assigned roles to play, but they are secondary. Thus, the lawyer advises on the legal aspects and doctors on the medical. They do not act as intermediaries.

Turning to Alaska, we must note that independent placements are not only permitted, but are the majority of adoptions. No evidence has been disclosed which points to corrupt practices in such adoptions in the state. The number of such adoptions is small. Our state is also small enough in population to guarantee that news of an actual corrupt practice would reach the proper authorities. This point, although obvious, is quite important to keep in mind. We might also assume that the courts are inquiring correctly into the background of independent placement adoptions.

We are now left with the basic concept that only a public welfare agency is equipped to handle all adoptions and to make proper background investigations of the parties for the court's benefit.

However, many professional persons who aid in adoptions will disagree that a public welfare agency is the only party equipped to arrange an adoption. Many members of the medical and legal professions have aided such adoptions. In so doing, they have assumed the responsibility that goes along with such aid. They have counseled the parties and no doubt have had knowledge of the background of the natural as well as the adoptive parents. They aid such adoptions with a belief that their efforts are humanitarian and will result in success.

To date, we have had no evidence to disprove that the great majority of such adoptions are successful.

It is true that an independent placement that is unsuccessful may be very difficult to correct. In this regard, the agency's participation in the adoption may make it easier for the adoptive couple to relinquish the child back to the agency. But it should be emphasized that it would take a very strong case to permit the adoptive couple to relieve themselves of the adoption in either case. Most adoptive couples understand the finality of the adoption proceeding and that they take the child for "better or worse, and through illness and health." Because of this, it is believed that independent placements are reviewed with caution and restraint by all parties.

There is also a practical side to allowing independent placements to continue in Alaska.

There is presently a shortage of trained social caseworkers in the state. Therefore, any switching of adoptions to full agency jurisdiction would no doubt result in a delay and hindering in adoptions in the state. Cases presently under agency jurisdiction are delayed due to the shortage of trained personnel. It would seem ill advised to add to the burden at this point.

A partial solution to the problem of trained personnel is to permit private agencies to enter the field of adoption. The 1967 legislature passed a bill permitting such private agencies to handle adoptions when licensed by the state. The legislature did not set up any standards for their operation, and to date, the Department of Health and Welfare has not promulgated any regulations on their operation. It is thus too early to know what impact they will have on adoptions and also what standards will be used. Perhaps the entry of private agencies will result in their handling independent placements.

The question of standards in handling adoptions is a very crucial one. Most of the

criticism leveled at agencies concerns adequate regulations.

In this regard, the Division of Public Welfare might be cited also. There are no formal regulations governing the handling of adoptions under its custody. Such standards are necessary in order that a person might understand what requirements he must meet. We might also mention that the court has not formulated any rules on adoption.

Under model legislation, the public welfare agency would have custody of all children to be placed for adoption and with such responsibility would go the job of caring for them during the interim period. There is presently a shortage of adequate facilities to house children under the custody of the Division of Public Welfare and a change in our law at this point adding to the number of such children without satisfactorily eliminating this problem might prove quite disastrous.

Because of the foregoing, it is felt by the writer that independent placements of children for adoption should not be prohibited in the state at this time.

### RESIDENCY

Model legislation suggests that the adoptive couple be resident of the state in which they adopt a child. Because an adoptive couple might have been refused an adoption elsewhere, it is argued that they could thus go into another state and adopt a child and return to their own state. But the court can easily ascertain whether or not an adoptive couple has been refused adoption elsewhere during the adoption proceeding. With Alaska's residency requirement being one year and the large number of military personnel in the State, it would seem that a tight residency requirement could very well curtail the number of adoptions, although persons might be qualified to be parents.

### UNWED MOTHERS WHO ARE MINORS

A proposal that unwed mothers who are minors shall have the concurrence of her parents before being allowed to consent to the adoption seems like a reasonable change, since it may prevent undue influence from being exerted on the minor parent. Of course it can easily be imagined that the parents could just as well exert an unreasonable influence under the circumstances.

Possibly the unwed mother's child needs protection in such situation, more than the unwed mother. The solution might be the appointment of a guardian ad litem by the court for the child. The court presently has the power to appoint such a guardian under its inherent power.

### RIGHTS OF A DIVORCED PARENT

A change in the rights of a divorced parent towards their children might be examined for possible revision. As previously mentioned, the divorced parent who does not obtain partial or full time custody of his child need not consent to an adoption of the child. He does receive notice of the proceedings, but cannot prevent the adoption in the first instance. In many cases, this provision could be unjust to the parent. Many cases of divorce are uncontested and the parties may have agreed that the welfare of the child would be better served under the circumstances if the other parent had full custody. The court in the divorce action may thus follow the understanding of the parties, although it is free to rule as the facts present themselves. No determination has been made that one or the other parent is unfit to be a parent in such cases. But, later on, the consenting parent who gave up custody might find that he has lost all his rights to the child. Such a result is harsh and not justified. Of course, it may well be that our statute does avoid many arguments and fights and it might



be pointed out that attorneys can ably point this provision out to their clients. It is a legislative determination that should be made in this situation.

### CONCLUSION

The adoption proceeding is a legal fact finding session designed to test and prove whether or not an adoptive couple should be awarded the custody of a child. The court has the inherent power to make certain that its decision is supported by the evidence.

The social service agency does not play a part as advisor in the majority of adoptions in the state. However, the court may request aid should it feel the case warrants assistance. That it has not done so in the majority of cases can only mean that the evidence presented at the proceeding is satisfactory for a decision to be made.

Our adoption law may be against the modern trend of thinking and may need to be changed as our population increases.

It might be well to start planning for such

an eventuality. Possibly, a statewide conference on adoption might be held. Such a conference might be under the auspices of the Alaska Court System and the Department of Health and Welfare and presided over the Legislative Affairs Agency. Doctors, attorneys, caseworkers, city and state officials and the general public might attend and express their views. Possibly a standing advisory committee might be set up for further study, or else the Legislative Affairs Agency might be charged with the responsibility of further investigation and final report to the legislature with or without suggested legislation. Such a report would include a comprehensive review of the statutes in other jurisdictions.

The formulation of guiding principles and standards for adoption would be the focus of the conference. But without a clear understanding of how all professional groups can coordinate their roles in adoptions and the practical effect of changes, it is this writer's opinion that any major change in the adoption law would be inadvisable at this time.

The author of this comprehensive review of Alaska's Adoption Laws, Mr. Stanley Howitt is Assistant City Attorney for Anchorage and editor of The Alaska Law Journal, the publication of the Alaska Bar Association. He is a member of the Alaska Bar and also the New York Bar, and was in private practice before coming to Alaska in 1961. Mr. Howitt has been an attorney-counselor on the staff of the Legislative Council, presiding Magistrate in Juneau, and also an Assistant Attorney General. He joined the legal department of the City of Anchorage in 1966.

# WHAT'S NEW IN ADOPTION

CHICAGO--It's becoming easier to adopt a child, the black market in babies is almost gone, and adoption agencies have some new ideas on who is qualified to be an adoptive parent.

Sometimes even a single person is considered a suitable parent by adoption agencies--although this is still a rarity, notes the current (August) issue of Today's Health magazine, published by the American Medical Association.

The changing attitudes toward adoption are in part due to changing social conditions in this country, writes author Charles Carner.

There is no longer a scarcity of adoptable children--at least certain kinds of children. The shortage, instead, is in mature, qualified adults who will take on the considerable responsibilities of raising an adopted child.

Though adoptions have increased more than 50 per cent in the past decade, from 93,000 to 142,000 annually, the illegitimacy rate in the U. S. has trebled since 1940--to 275,000 a year.

Of an estimated 2-1/2 million children under 18 who were born out of wedlock, about 31 per cent have been adopted. Agencies are aggressively seeking more parents, particularly for the hard-to-place child.

And who is the "hard-to-place" child? Sixty-three per cent of illegitimate births are non-white children, but the number of non-

white couples volunteering as parents falls far short of this number. The handicapped child also has a hard time finding a home.

There is no shortage of Jewish parents seeking adoptable children, but there is a need to find homes for interracial Jewish children--those born out of wedlock to white Jewish women and Negro Christian men.

A New York City group known as the Commission on Synagogue Relations, composed of rabbis and laymen, is working in conjunction with the Louise Wise Services, the major agency that serves predominantly Jewish unwed mothers. In the past three years, the groups have placed 117 children through this program.

Of these, mostly with Negro fathers, eleven were placed with white couples, five of whom are Jewish and six of whom are Christian. The rest were placed with Negro Christian families.

About 25 children have been placed across the nation with especially appropriate single parents. A Chicago attorney specializing in adoption cases tells of a physical therapist, a woman, who adopted a physically handicapped child.

She helped the youngster become more self-sufficient over a period of about three years. Today, he is a reasonably well-adjusted youngster.

"As a rule, however, agencies don't



believe that trading one single biological parent for a single adoptive parent is an improvement," the attorney said.

The black market in babies which thrived after World War II has virtually ended as a result of several factors. Several states tightened adoption laws as a result of a Senate committee's investigations in the 1950's.

Several groups worked together to develop model legislation which has been adopted, with some modification, by several states. Among those co-operating were the American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American Academy of General Practice, American Bar Association, the Children's Bureau, the Child Welfare League of America, and the AMA's Committee on Maternal and Child Care.

This new legislation provides for non-agency adoptions, but requires a preliminary family study by a recognized adoption agency.

"Independent placement" is not illegal in most states, providing no child broker profits from arranging the adoption, and the mother has agreed to the placement. Cost usually runs from \$1,000 to \$2,000; the adoptive parents usually pay the mother's hospital bills, plus a lawyer's fee for drawing up adoption papers. Non-agency adoptions by out-of-state families have been eliminated.

While loop-holes which disregarded the child's welfare have been tightened, other arbitrary policies governing adoption by agencies have been eased, mainly as a result of the changed ratio of children and qualified adoptive parents.

This is an agency change in viewpoint "from serving as a child finder for adoptive parents to serving as a parent finder for adoptable children," author Carner wrote.

Some agencies specialize in serving racially mixed children. Pearl S. Buck's agency in Bucks County, Pennsylvania, is particularly interested in Oriental-American babies and the children of American servicemen.

Since the late 1940's, WAIF-International Social Service has arranged adoption of 17,000 "trans-racial" children, mostly from Korea, Hong Kong, and West Germany.

One of the most successful programs for racially mixed children operates in Toronto. Started in 1952, it now is a co-operative venture between the Social Planning Council of Metropolitan Toronto, the Children's Aid Society of Metropolitan Toronto, and the Catholic Children's Aid Society. Financed by the Laidlaw Foundation and the Canadian Save the Children Fund, the groups recruit both white and Negro adoptive parents for Negro and part-Negro children. Between 1963 and 1965 the agencies placed 93 Negro children, 70 with white parents and 23 with Negro parents.

Perhaps the most heartwarming effort of all, Carner said, involves partially handicapped children in California. An 11-year study by the Children's Home Society of California shows that several children, aged 5 to 16, with differing degrees of handicap, have successfully joined adoptive homes.

An adoption agency's greatest challenge remains the proper matching of child and parents.

"In the 1930's parents had to be sterile before they could adopt children. Fifteen years ago, two children were the maximum. Now we place as many as six children with a family," said David S. Franklin, D.S.W., director of research, the Children's Home Society of California.

"No longer should we rule out a couple because they say something 'questionable'. (Agencies) should help them understand their attitudes, work with them a little longer so that they won't, for example, look down on the biological parents of the child--because this tends to make them look down on the child. They (parents) have to accept a wide range of differences, and relax hard and fast rules," he said.

# LIVING WITH SUBSTITUTE PARENTS

**By Edith Skinner**

*Child Welfare Worker*

'I want my baby to get well.' So said an Eskimo mother six years ago when the newborn's illness made it necessary to fly her to the United States Public Health Service Hospital in Anchorage from the remote village of Marshall. She has never been able to return home except by way of photographs exchanged between her mother and her foster mother.

In 1966, 155 children lived in foster homes in Anchorage away from their own families. Why? These children needed health services and physiotherapy not available in their villages. Most of this number have been returned to their homes after their medical needs have been evaluated and treated. However, more and more children are found in the villages that require the more comprehensive evaluation that can only be obtained in the metropolitan area of Anchorage, but where do we house them? Where are the families who can accept and understand a physically ill or troubled child needing temporary home care and not a hospital? How are the parents of these children given the assurance that their child is being loved and protected?

Are there other children besides those who have medical problems that are in need of foster homes? 'Isn't he cute or cuddly' or 'isn't she sweet' are words heard from the foster mother who comes to the office to talk over with the social worker the length of time and care she would provide until the baby is clear medically and legally to be placed for adoption in one of the state approved permanent homes. There are children whose parents have had little or no nurturing and are unable to provide for maximum development and security due to their own parents' failure. They reject their children as once they too had been rejected or resort to brutality to compensate for their own

unfulfilled need for nurturing. This cycle can be stopped with a successful placement where the needs of the child are considered first. The adolescent who has expressed feelings in a socially unacceptable manner can find understanding and encouragement in a placement where foster parents are willing to set limits within the framework of the specific needs of the teenager.

The Sessions Law of Alaska set down in 1935 and revised in 1951 authorizes the Division of Public Welfare to license homes who care for children not related by blood or marriage. This agency, a division in the State Department of Health and Welfare, also promulgates rules and regulations covering standards in the selection of a foster home. Prior to the issuance of a license for a 12 month period, a formal application is filled and interviews with the prospective foster family takes place in the agency office, as well as in the home in order to help determine the capacities of this family to nurture and care for children, as well as the adequacy of the physical facilities. It is mandatory that the applicants have a tuberculosis test as evidence that they are free of this contagious disease. If the home is on a private well, a water sample is required and analyzed by the state laboratory. There is no cost to the prospective foster parents for these required tests, but it is their responsibility to complete them.

How are foster parents selected? There are many persons who would like to be foster parents but are not accepted under the present criteria used. It should be stated that in some instances exceptions have been made. Generally, foster parents should be of good character, habits and reputation. They should be accepting of a child and willing to help him be



a part of the family. They should be able to handle an emergency situation promptly and intelligently. They should be willing to cooperate fully with the supervising agency. Foster parents should have an understanding and a capacity to meet the physical, emotional, social and spiritual needs of children. The home shall be a family unit with both a mother and father person, except in certain situations where the single foster parent has the particular qualities and skills needed by a specific child. The foster mother should be able to devote the necessary time for care of the foster child. Infants and young children are never left alone without competent, adult supervision. Homes providing other types of care for children or adults cannot be used for foster care. There should be sufficient, assured income to cover the basic needs of the foster family. The reason for wanting to be a foster home should include a sincere love for children, an understanding of child behavior, sensitivity to their needs and ability to separate from a child with appropriate feeling when the time comes.

The limitations placed on the physical facilities of a foster home specify that each child must have a bed alone, other than with a sibling of the same sex. Children over six years of age can share a bedroom but only with children of the same sex. Infants over six months cannot sleep in the same bedroom of the foster parent except when the child is ill. The number of children, including the natural children, can be no more than five, and of this number only three pre-schoolers or two infants up to two years of age can live in one foster family. Safety factors in the home are taken into consideration.

It is the responsibility of the agency to make the decisions regarding further planning for the foster child. Therefore, carefully worked out relationships between the agency and the foster parent are essential for the best care of this child. The responsibility of

providing twenty-four hour care, love and attention rests with the foster parents.

What are some of the questions asked by foster parents regarding foster care? Is it a permanent placement? Is the child removed when we become 'too attached'? Can we adopt the child? These questions can be answered generally as well as specifically. Foster care is not to be considered permanent. It is expected and desired that the foster family will become attached to the child, according to his own need for this attachment, but the child is never removed from a foster family on this basis alone. A foster home must be prepared to love someone else's child, satisfy his physical and emotional needs, cooperate with the social worker and the child's own parents, and then willingly help him move on to his next life situation when it is indicated. If the family desires to have a child permanently in their home, the foster home program is not suggested for them but rather that they apply to become parents under the adoption program.

In the month of April, 1967, there were 459 children, either in institutions or foster home placement, under the Division of Public Welfare in Anchorage, waiting further social planning. These children had been neglected, abused, abandoned or relinquished by their parents, as determined by investigation through the juvenile court order. Foster homes are also used and needed for the child who has been adjudicated as a delinquent. The need for more foster homes is an ever-existing and unending problem. Although there are approximately 150 licensed homes in the Anchorage district for this agency (the number varies from month to month), it is not sufficient to meet the needs of the increasing number of children who cannot be helped in their own homes. Where are the homes that are willing to work through the problems of a child not of their own blood relation? Where are the foster families who can fit the needs of the child and are willing to make adjust-

ments? There are not enough homes that meet the specific needs of teenagers nor are there homes that are able to accept the emotionally or mentally handicapped child without training and close supervision. Part of this lies in the reality of a lack of a training program for foster parents, as well as the shortage of social workers to work with the child in his own home. However, there are some children whose needs cannot be fulfilled in a foster

home setting and the need to establish group homes for the troubled adolescent is increasing. There are times when institutional care is the answer for the severely affected child that cannot live in a family situation.

A booklet entitled 'So You Want To Be Foster Parents' is available through the Division of Public Welfare, locally, at 527 E. Fourth Avenue, telephone 279-3431, for persons interested in becoming foster parents.

## ADOPTION DISCUSSION

**By Peter J. Koeniger, M.D.**

An Alaskan physician called upon to participate in an adoption may arrange for placement of the newborn infant in the home of adoptive parents independently, or he may refer the problem to an adoption agency. (At present, the Division of Welfare of the State Department of Health and Welfare represents the only available adoption agency, although other private or church-affiliated agencies may be licensed in the future.)

Leaving the choice of adoptive parents to an agency social worker may sometimes be preferable or necessary. However, in many situations the local physician is in a much better position to assess the suitability of a couple as adoptive parents than some social worker from a distant governmental office.

If arrangements to handle an adoption through the Division of Welfare have been made prior to the delivery of the infant, this agency has usually paid the physician a fee for medical services to the mother and newborn infant. Until recently, this fee, however, was not based on a bill for services from the attending physician but was set arbitrarily at a lower figure by the Division of Welfare.

Bureaucratic delays and red tape in the Division of Welfare have embittered some

adoptive parents, mothers and physicians in past years. Thus many have come to feel that independent adoptions often do a better job of providing newborn babies with prompt, loving care by responsible adoptive parents, than has been accomplished by cumbersome agency procedures.

It seems clear that there is a continuing need for both agency adoptions and independent adoptions in Alaska, and the Alaska State Medical Association has consistently opposed any changes in law that would make it mandatory for all adoptions to be handled by a public agency.

To keep participation in independent adoptions ethical and desirable, the physician should:

1. when asked to choose adoptive parents, realize a moral obligation to choose persons of sound moral, physical and mental qualities, befitting parents.
2. charge no more than his usual fee for professional services rendered in the care and delivery of the mother and care of the infant.
3. instruct the adoptive parents and the mother to obtain legal counsel.
4. be sure that the newborn child is examined and is medically suitable for adoption.



# ADOPTIONS IN ALASKA

**By Harvey Zartman, M.D.**

You had asked me to comment on adoptions as they are now undertaken in the State of Alaska. I and my colleagues in pediatrics do not have any direct control over adoption procedures or placements. We do examine almost all of the babies who are available for adoption in the local hospitals through the Department of Welfare and the Booth Memorial Home Setup. Several years ago many of these babies were discharged from the nursery to foster homes, where they remained for a variable period of time before being placed in permanent homes, and this is a situation that is fraught with hazards to the baby as the risk of the baby's being relegated to a "baby farm" for an indeterminate period of time. I think Alaska was particularly fortunate in having a welfare department that was anxious to get the babies into permanent homes as quickly as possible. At the present time efforts are being made for the infants to go directly from the newborn nursery to their prospective homes. This requires a good deal more hurrying on the part of social workers in placing these individuals. Certainly the children that I have followed after they were adopted have been fortunate in obtaining lovely parents.

An alternative method of adoption which has been jealously guarded by the physicians in this state is that of direct placement by physicians, usually obstetricians, of "no info" babies to homes that these physicians have selected by their own experience and

knowledge of the prospective adopting parents. I can think of no great number of cases where babies suffered through this route of adoption. Certainly there have been instances where adoptions were carried out that would not have been permitted by social workers trained in the conventional standards of selecting prospective families; however, several children who would have been totally unadoptable by present standards are growing up in lovely homes and would be unwilling to trade in their parents just because of lack of adequate funds or lack of adequate number of bedrooms, etc. -- criteria which are often used in selecting appropriate families. I feel that it is a tremendous burden on the conscience of any doctors placing little ones for adoption to know that they have selected as carefully as possible an ideal family for the baby. In Alaska there is a waiting period until the infant is six months of age before adoption can be finalized. In one recent case, this six-months waiting period served a powerful role in saving one child from an otherwise unfortunate home. On the other side of the coin, parents have been protected from adopting babies who were hopeless medical problems when such problems were not obvious in the newborn nursery. As long as there is such a safety valve to enable alert physicians, ministers, attorneys, etc. to interrupt definitely undesirable adoptions, I see no reason to change the present system of placing infants.

## ADOPTION

You asked for my thoughts regarding adoptions in Alaska in light of an effort to further regulate adoptions through legislation. Government is supposed to confine its efforts to

**By William H. Ivy, M.D.**

serving the people in areas where free enterprise cannot adequately provide such service. Our state government has already taken on more governmental functions than it can ad-

equately perform and thus should take on no more unless an absolute need is established. I have been handling the obstetrical part of adoptions in Alaska now for eighteen years with good results and no complaints. I have also observed that the Welfare Department handles those cases of adoption where indigency, race or some other problem precludes their being handled through the private practice of medicine.

Just as it is a right for a patient to have his ulcer treated by a doctor of his choice under the free enterprise system, so should it be the

right of an adopting parent or unwed mother to arrange adoption through a physician of her choice and in whom she has confidence. In handling adoptions, I find it best to keep them bilaterally anonymous, have the adopting parents provide a lawyer of their choice to act as their representative in the transaction and handle the legal matters and have a pediatrician perform a pre-adoptive physical examination on the child for additional assurance of its health status.

With these thoughts in mind, I am presently opposed to any change in Alaska law affecting adoptions.

## WHAT IS ADOPTION?

By L. David Ekvall, M.D.

What is adoption? 'The acceptance by free choice of an obligation or a duty.'

When we accept the responsibility of placing a child in a home, we have within our hands the destiny of a child not knowing the opportunity and frustrations of life as well as a husband and wife who have a burning need for the expression of love. One cannot look only to the child or only to the adopting parents as the main purpose in adoption, rather one must take into account the lives of all involved.

I feel that the placement of a child in a family can be more adequately done by a physician who is willing to accept this obligation than by any health organization in the world. You say 'Why?' Because he will personally know the family that child will be brought up in, rather than decide on a cold, statistical, memorandum type of evaluation too often based on the idiosyncrasies of an elderly

social worker. For example, I personally feel that every child should have the opportunity of higher education and exposure to Christianity. I think the size, shape, personality and genetic background of both child and parent should match so as to produce a harmonious uniform composite family. In addition, we, as physicians, have accepted an obligation not only to place a child in a family and seal its destiny in many ways, but also play an integral part in putting back into society a whole individual who, yes, made a mistake, but a mistake that does not have to destroy that individual.

In closing, I feel that the conscientious, genuinely interested physician is in a multitude of ways better suited to evaluate a mother, a child and deserving couples, in the placement and destiny of a new human life, than any public agency that I have had the opportunity to know.



# ADOPTION CONCLUSIONS:

## Legal and Medical Costs for Adoption

Over the past several years the attorney's fee for a routine adoption has remained steady at about \$150.00 in the Anchorage area. Medical charges usually run under \$300.00 for an uncomplicated case. They are customarily billed to the adoptive parents in the common case of the illegitimate newborn, and include antepartum, delivery and postpartum obstetrical care. Hospital costs commonly run up to \$400.00. There may also be a smaller charge for a pediatric evaluation for adoptability, and minor court or legal charges. This means that the adopting parents of a newborn who choose not to adopt through the Department of Welfare will usually have to pay about \$900.00.

## Conclusion:

A review of the several articles in this issue as well as much unprintable information obtained in conversation lends support to the status quo in permitting private adoptions. Unquestionably the State Department of Welfare is not and never has been staffed in a manner adequate to permit efficient and humane coordination of the human beings involved. Many reports of interminable delays, either on technicalities or just because of not enough help,

support the present alternate route for bypassing the Department of Welfare.

Even under ideal circumstances the social worker in charge of a case may unconsciously tend to remake the world in her own image. Certainly she usually has the least to gain or lose. This can possibly contribute to fairness; it certainly promotes delay. And time lost, often while a child lives in an institution or foster home, cannot be regained. In some states the 'foster home business' is a racket. Even in this state it provides a good income to many, although the quality of foster parents appears excellent, by and large.

Most observers appear to agree, at this time, that Alaska is not ready for and does not need a more powerful Welfare voice in adoption procedures. Rather we could hope that the present administration will be able to relieve the chronic personnel deficiency, and the work overload now weighing down the Department, in order to upgrade their present performance. This, for example, should decrease the need for and cost of the foster home program. It is well to keep in mind that very few of us parents might have had children naturally if we had first required permission from a social worker.

## FOR YOUR INFORMATION

### AMA JUDICIAL COUNCIL RULING

Charging penalties for over-due accounts is unsuitable in the medical profession in the opinion of the AMA Judicial Council.

"It is not in the best interest of the public or the profession to charge interest on an unpaid bill or note or to charge a penalty on fees for professional services not paid within a prescribed period of time, nor is it proper to charge a patient a flat collection fee if it becomes necessary to refer the account to an agency for collection."

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Annual Meeting, 1968, September 22-25 (Olympic Hotel, Seattle).

# ON CHRISTMAS AND POTLATCH

In past years an undue amount of emotionalism and even religion has prevailed during the Christmas holidays. Now that Christmas is free of church influence, and under the guidance of the Chambers of Commerce, a review of the basic 'principles of giving' is in order. With minor modifications this guide can also be used on 'Father's Day', 'Mother's Day', 'Valentine's Day' and so forth. It is hoped that in some small way this review will encourage a more realistic and profitable approach toward Christmas by gift purchaser and shop keeper alike.

The Christmas gift should always be considered an investment. (We shall not here concern ourselves with the occasional gift to a dear friend or loved one.) To make a good investment one must of course plan for maximum return at minimal expense. It should be apparent that the actual purchase price of any gift ought never to be known to the recipient, except in the special category of lavish gifts (see below).

The first rule of Christmas giving is that purchased articles must appear more expensive than they are. This implies that in addition to obliteration or substitution of price tags the article should not be common, and thus easily priced; cannot be useful, for if cheap and useful it will soon become common and thus easily priced; and should be heavy for its size with a good gold plate or veneer which will wear at least through the holidays. Weight has long implied value to primitive peoples, as for example with the great stone money wheels of Yap.

In addition the Christmas gift should be difficult or preferably impossible to identify. This means that it can't be priced; it can't be worn out if it can't be used; and it is not likely to be discarded as it may be of value. Also by

implication the recipient is placed among those 'who have everything' and, as with the invisible clothes of the king, he is among those 'best people' who can really appreciate this gift. Finally it embarrasses the recipient not to know what to thank you for. All of these factors lead to uncertainty and increased return-gift values.

By these rules we can now describe the ideal general category gift. It should be heavy, inexpensive, and made of shiny metal and dark wood. Preferably it should have moving parts and be unstable in any position to avoid its being mistaken for a bookend. It should also have been purchased at an unknown place and time to avoid any possibility of return or exchange, as this could both identify and price. Usually it is considered good follow-up form for the donor of such a general category gift to casually inquire about his gift on a subsequent visit to the recipient. This further embarrasses and obligates the recipient, who will be unable to promptly produce the gift in good condition under circumstances implying that its use was known.

Let us suppose now that one becomes the recipient of such a geegaw or gimcrack. In this case an acceptable ploy is to pass over the gift lightly, and then store it for one to two years in a cool dry place. It can now be given to someone else or even back to the original donor. Such a progressive or return gift fulfills many of the important criteria mentioned. For example, the purchase time and place are now remote. If the original donor should happen to recall this gift, one can easily explain that this little beauty, just like the one he gave you, was found only after prolonged searching.

Under any circumstances, whether giving for compensation (barter) or retribution, the importance of keeping adequate records can-



not be over-emphasized. Lack of prompt recall and proper preparation can lead to embarrassment and loss of investment. All undesired gifts should be promptly and accurately labeled to show person and place and origin, and the date of receipt, as well as witnesses when indicated. Proper storage of useless and flamboyant gifts is essential, although sometimes impossible. An occasional loss will have to be chalked up to experience, such as the smoked pheasant under glass that turned green after three months. Such losses can however be minimized by careful planning. At times a prompt gift to charity may be expedient, deductible and embarrassing to the donor.

The lavish gift is a special case which brings out many of the important aspects of Christmas giving. There are two main indications for a very lavish Christmas gift, excluding its occasional use as a real gift. The first is simply as an investment in expectation of a greater return. This need not be further considered, except to remind the donor of the obvious need for careful planning, including such delicate hints as may be required to assure proper return-gift selection.

The second indication for a very lavish gift is retribution. Here the object is to shame and character assassinate the recipient publicly. This modern version of the potlatch also requires careful preparation. First the surprise element must be preserved, as thereby

hangs the success of any ambush. Usually several Christmases in succession are required to establish a low value level of exchange. Small items from Japan or Hong Kong are often satisfactory, but this will depend upon the level of lavishness being planned. Secondly a simultaneous exchange of gifts is mandatory, in front of the largest possible group of relatives and friends. It is best to allow the surprised recipient to open his gift first, and casually watch him utter a weak and embarrassed 'thank you'. Then one can slowly, deliberately, and with ill-concealed anticipation unwrap one's own gift. At such a time a well rehearsed ecstasy of not over fifteen to twenty minutes is usually adequate to express gratitude for a two dollar gift. This will generally eliminate the competition.

A judicious reminder and rerun of this episode is recommended thereafter at intervals if such a lavish gift is to be of truly lasting value. When a lavish gift is given to a business acquaintance or partner, it can be deducted as a payment for services. In this case one should consider reporting the recipient for income tax evasion, as almost surely he will not include this gift on his income tax statements. This of course is not always applicable.

It is hoped that even this brief review of the principles now basic to Christmas giving can help support and guide the gentle reader through the difficult days ahead.

Anonymous

# FLYING-SAFETY IMPROVEMENTS SUGGESTED BY AMA

In a move to improve flying safety, new procedures for certifying pilots' physical fitness were recommended recently by the American Medical Association's Committee on Aerospace Medicine.

The AMA recommended that a pilot-license applicant:

1. Be required to name all physicians who have examined or treated him, and,
2. Sign a release authorizing these physicians to supply pertinent information from medical records to the Federal Aviation Medical Examiner or other FAA physicians before certification of the pilot license.

These measures "would protect the public safety before an accident attributable to pilot impairment happens," said the statement, which appears in the September 11 Journal of the AMA.

Such a change would require no legislation, only a change in FAA regulations.

Physicians face ethical and legal dilemmas under present pilot-examination procedures, the statement pointed out. Despite careful medical screening under the FAA's Medical Examiner system, pilots occasionally slip through without revealing significant impairments for which they are under treatment by another physician.

Some problems may be unknown to the Medical Examiner, but well known to the pilot's personal physician, such as habitual alcoholism, severe emotional or mental states, epilepsy, temporary heart irregularities, or use of tranquilizers, antihistamines, LSD, or narcotics.

Should a physician reveal such problems to authorities? His conscience may tell him to do so, but the doctor is legally liable for

such disclosures unless authorized by the patient.

Last year, 83 deaths resulted from the crash of an airplane whose pilot was taking medication for both diabetes and cardiovascular disease. His pilot license had been re-certified two months earlier, without knowledge or evidence of his impairment.

"Such an event dramatically emphasizes the ethical problems of any physician who has under his care a patient who possesses an FAA pilot certificate, whether he be an airline pilot, a business pilot, a private pilot or an air traffic controller in an airport tower," the statement said.

There are approximately 500,000 pilots in these various categories in the United States.

"The private physician cannot be expected to know all the details of the disqualifying items in the medical regulations and standards of the FAA," the statement said, "Nor can he easily justify under prevailing ethical principles the revelation of confidential medical information acquired in the physician-patient relationship."

"Yet, the physician is faced with the possibility that failure to reveal such information may carry responsibility for a disaster involving the deaths of his patient and of many other innocent people."

As suggested by the AMA's Judicial Council, the change in FAA procedure would solve many of these problems by an entirely ethical method.

"It would place the authorization for reporting squarely on the (pilot license) applicant, where it belongs," the statement said. It also would protect the reporting physician



by documenting the applicant's consent to such reporting.

There have been other alternatives proposed, but each of these has serious drawbacks, the statement said. The suggestions include (1) Federal or state legislation absolving the physician from suit for voluntarily reporting such information to the FAA, (2) a federal statute requiring mandatory reporting by the physician, or (3) encouragement to physicians to make such reports voluntarily in the interest of public safety.

"The Committee on Aerospace Medicine believes that a mandatory reporting statute would be unenforceable, and undesirable for many reasons. But the Committee favors voluntary reporting by attending physicians where illness or potentially disabling conditions in the pilot clearly constitute a hazard to the public safety," the statement said.

"If the consent of the patient is obtained, there is no violation of medical ethics. Without such consent, the physician must consult his own conscience, and probably also the committee on ethics of his medical society, in determining the balance of potential consequences to his patient, and to the community. In borderline cases he may advise his patient not to fly, and state that he has recorded this in his clinical record, which could be helpful in the event of later accident investigation."

The statement stressed, however, that the pilot's failure to comply with this advice would

not avoid an accident, whereas a report to appropriate authority would.

"The physician's responsibility to the community is an increasingly important factor in such decisions. The decision to report, against patient's wishes, is akin to that involved in the reporting of venereal disease, gunshot wounds, or the battered child syndrome, where the life or safety of others, as well as those of the patient, may be involved."

If the pilot fails to cooperate in revealing his impairment, the personal physician is the only recourse for protection of the public and the pilot himself, the statement said.

The physician's care of the pilot's safety, and that of the public, "are inseparably linked, and may require violation of confidentiality as the lesser of the evils among the alternatives present in the situation."

The AMA's Committee on Aerospace Medicine and Judicial Council suggested the pilot-licensing procedural changes because they "are preferable to any mandatory legislative approach to the choices the physician must make in these difficult grey areas of ethical conduct."

"No formulas can be comprehensive or absolute. Nothing can be successfully substituted for the careful judgment of the physician in each individual case," the statement said. "But the increasing involvement of the public safety in this area of medicine is... a factor which must be considered, along with the physician-patient relationship, if restrictive and unwise legislation is to be avoided."

# REVIEWS OF RECENT BOOKS

By Barbara Brown

THE OFFICE ASSISTANT IN MEDICAL PRACTICE. By Portia M. Frederick and Mary E. Kinn, C.P.S. W.B. Saunders Company, 3rd Edition 1967, 461 pages.

This book is divided into two sections. The first is a thorough and competent secretarial primer; the second covers the basics of office nursing.

Each chapter, from 'Planning Your Work' to 'Assisting in Minor Surgery' covers the subject in detail, giving the reader a wealth of information necessary for her to do a good job. The chapter on 'Telephone Technique' was especially interesting and subtly amusing, with several typical telephone conversations and a drama on 'How to Lose Patients by Telephone'.

The office secretary will find the basics of her profession here. The essentials of book-keeping, often unique in a doctor's office, are covered. Also included are chapters on handling doctor's mail, billing and collecting and insurance processing.

The doctor's assistant, backed by the medical section of this book, should be ready for most office situations. Descriptions of instruments, methods of injection and inoculation and pharmaceutical information for preparing medications are given and should prove helpful to the office nurse.

This volume contains material which will not be used by the secretary and some that is unnecessary for the nurse, but it provides much of value for each. With The Office

Assistant at hand, most office problems should be swiftly resolved.

LEARNING MEDICAL TERMINOLOGY STEP BY STEP. By Clara Gene Young and James D. Barger, M.D., C.V. Mosby Company, 327 pages, \$7.50.

Written mainly as a textbook for training paramedical personnel, this book aspires to be a tool for 'unlocking the mysteries of medical terms'. The 'step-by-step' method of presentation, giving terminology in context with anatomy and physiology, will provide the medical understanding and language necessary for any paramedical work.

Poor material organization, however, accounts for its failing as a ready reference for the trained employee. The general index is inadequate, giving only single references for many words found elsewhere in the book. Glossary words are not indexed. The word 'aneurysm' for example, although well defined in the glossary on the circulatory system, is not in the text and therefore omitted from the index. The glossaries themselves, accompanying each chapter, are confusing. To the medical assistant seeking information on a certain word this book would seem an enigma.

In approaching terminology through anatomy and physiology the authors have written an excellent text for the paramedical student. By emphasizing anatomy and physiology, however, this book loses its quick reference value for the employed medical assistant.





## CLASSIFIED AD SECTION

This classified ad section is provided to give members an opportunity to make known their needs for medical and paramedical personnel. Please address all correspondence regarding insertions to: Robert G. Ogden, Executive Secretary, Alaska State Medical Association, 519 W. 8th Avenue, Anchorage, Alaska 99501.

### THE ALASKA STATE MEDICAL ASSOCIATION

Physician Placement Service has the following number of physicians listed as interested in practice in Alaska. For names and addresses please contact the Alaska State Medical Association office at 277-6891 or 519 West 8th Avenue, Anchorage, Alaska 99501. Anesthesiology 4, Ear, Nose, Throat 1, General Practice 8, Internal Medicine 5, Neurology 2, Ob-Gyn 3, Ophthalmology 3, Orthopedics 1, Pathology 1, Pediatrics 2, Psychiatry 2, Radiology 1, Surgery General 2, Surgery Pediatric 1, Surgery Plastic 1, Urology 5.

OB-GYN ASSOCIATE opening available; preferable to be board certified, will consider board eligible. Reply to L. David Ekvall, M.D., 207 East Northern Lights Boulevard, Anchorage, Alaska 99503.

GENERAL PRACTITIONER WANTED — ASSOCIATE POSITION: this opening includes plans for a possible future partnership. New office with all facilities available. Contact Royce H. Morgan, M.D., 1844 W. Northern Lights Blvd., Anchorage, Alaska 99503.

THE FAIRBANKS MEDICAL AND SURGICAL CLINIC announces opening for general practitioners, internists, and pediatricians. For particulars please contact the Business Manager, Fairbanks Medical and Surgical Clinic, Box 1330, Fairbanks, Alaska.

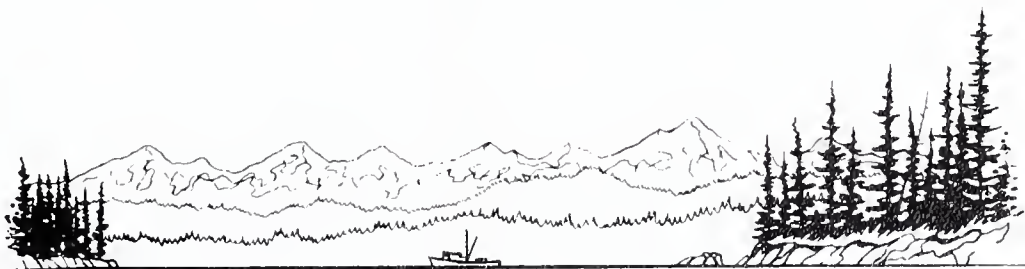
FOR LEASE—Joseph M. Deisher, M.D., has an office for lease next to the Seward Hospital. The office is equipped with all equipment necessary to start one doctor in private practice. For further information contact Doctor Deisher at ORME, 901 South Wolcott Street, Chicago, Illinois 60612.

SOLO IN ANCHORAGE - Immediate opening for a physician interested in a solo practice in Anchorage, Alaska. Good downtown location, reasonable rent, offices and equipment all set up. See at the Medical-Dental Building, 140 East 5th Avenue, or telephone H.A. Nahorney, DMD, MSD at 272-7033.

ANCHORAGE MEDICAL & SURGICAL CLINIC announces openings for Internist, General Practitioner, and Orthopedic Surgeon. Would like young men under 40 with military obligations fulfilled. If interested, contact: Howard G. Romig, M.D. 718 K Street, Anchorage, Alaska 99501.

SEWARD IN NEED of full time physician. Hospital available, rural population, scenic center of excellent hunting, fishing and outdoor activities, ideal family environment. For information contact Mr. Arthur King, Administrator, Seward General Hospital, Seward, Alaska.

INTERNIST: The Tanana Valley Medical Clinic has an opening for an internist. Would like young man under 40 with military obligations fulfilled. If interested please contact Mr. Al Seliger, Business Manager, 1007 Noble Street, Fairbanks, Alaska.



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# ALASKA Medicine



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JUNE 5-8  
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# ALASKA MEDICINE

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519 West Eighth Avenue, Anchorage, Alaska 99501

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## IN MEMORIAM

# ROBERT D. LIVIE, D.M.D.

**Born 13 June 1909**

**Died 26 January 1968**

Dr. Livie was born in Juneau, Alaska. He obtained his Dental degree from the North Pacific College of Dentistry, now the University of Oregon. At different times he practiced in Seward, Valdez and the Bristol Bay Area. He maintained his practice in Anchorage from 1937 on, with the exception of a four year period during World War II while he served with the U.S. Army.

Dr. Livie served on the Anchorage City Council from 1960 to 1963 and was a member of Alaska Igloo No. 15 and Anchorage Lodge 1351 B.P.O.E. He was a prime organizer and the first President of the Alaska Dental Society, a past President of the Anchorage Dental Society, fellow in the International College of Dentists, and past Secretary of the Anchorage Dental Research and Educational Group.

Funeral Services were held Tuesday, 30 January, 1968 at All Saints Episcopal Church, Anchorage, the Rev. Norman H.V. Elliott officiating. Active pallbearers were Dr. Glen



O. Gould, Dr. Robert A. Smithson, Dr. Luther L. Paine, Eino A. Reinikka, Thomas T. Walker and Osky Weeda. Honorary pallbearers were William A. Besser, Ben Boeke, Dr. Lee L. McKinley, Dr. A.R. Roberts, Dr. Robert Brodie and Dr. Foster Sims.

Interment was in the Elks Garden of the Anchorage Memorial Park. Memorials may be made to the Elks Cerebral Palsy Fund, Anchorage Lodge 1351 B.P.O.E. or to a charity of your choice.

Dr. Livie is survived by his widow, Mrs. Frances Livie, five children, Mrs. Tanya Pierce, Seattle, Mrs. Robert Hennington, Wichita, Kansas, Jay Norman Livie and Miss Virginia Livie, both seniors at West Anchorage High School, Miss Kathleen Livie, a sophomore at West Anchorage High School and his step-mother, Mrs. John Livie, Seattle.



# ALASKA DEPARTMENT OF HEALTH AND WELFARE PAGE

By J. Scott McDonald

*Commissioner*

## WATER POLLUTION

Notice of approval of Alaska's water pollution control program plan for 1968 has been received from the Federal Water Pollution Control Administration in Washington, D.C. just at the time when water pollution incidents are receiving great attention throughout Alaska.

The increasing complexities of water pollution were the subject of the keynote address in mid-December at the Columbia Plateau Resources Council annual meeting. R. F. Poston, Northwest Regional director of the Federal Water Pollution Control Administration, pointed out to an audience of experts in the field that:

"Water pollution becomes more and more complex--in both scientific and social-political terms--and costly to resolve as we talk about it today. Arresting the rising tide of pollution is a challenge, indeed--one requiring not only a heavy commitment of manpower and money but a willingness to adopt new patterns of thought about our water resources, leading to wise water use, not exploitation.

"Unfortunately, most of the public discussion of water pollution appears as a struggle between the public regulatory agencies and a polluter. Charges of 'infringements of right' and 'hindrances to progress' cloud the real issues--recognized nearly unanimously in the State and Federal legislation--that the future development of the Northwest and the country will depend upon adequate supplies of usable water.....

"The new goals of our affluent society are for concurrent economic growth and a clean

environment. The goals have been established after thorough debate in legislative chambers. Now, the State and Federal administrative agencies must carry out the public mandate or be derelict in their duties. The job today is to stop debating the need for pollution control and to put our energies to work in finding the most effective and economical means of control.....

"The key element in water pollution then is the usability of water. Beneficial or legitimate uses of water form a long list: Water flowing in a stream or in a lake has an esthetic value; it is used for recreational boating, swimming and fishing; it must support the propagation of our fish and aquatic life, and wildlife; it must permit navigation; it produces hydropower; and, finally it assimilates the residual wastes of our city and industry treatment plants.....

"In the middle 1960's, we have seen a concurrent strengthening of both State and Federal laws, and the authorization of hundreds of millions of dollars for federal pollution control programs and grants. For the first time in the evolution of pollution control law, we now have State and Federal authority to do more than react to water quality crises. Now we are activating the foresightedness of the early conservationists to preserve our environment for the future.

"The emerging role of the Federal government has been due largely to inaction by State and local governments in controlling a public problem. The State agencies have seen the need for action, but their authority and pro-

grams had been kept weak and ineffective purposefully by powerful groups of polluters and an apathetic public. But in the landmark Federal water pollution control amendments of 1965 and 1966, that apathy dissipated. Many sections of the amendments were designed to encourage and strengthen the State pollution control programs. In the Federal Act's strongest measure, establishment of water quality standards, the States were given the first and primary responsibility; but if they failed to act, the Federal government could do the job for them. All States exercised their option to set the standards, and most State legislatures have been active in providing the authority and funds for the State agencies to enable them not only to set the standards but to implement and enforce them.....

"The Act states that standards must protect public health and welfare, enhance the quality of water, and serve the purposes of the Act to prevent, control, and abate water pollution. It specifically calls for the standards to recognize the use and value of waters for public water supplies, propagation of fish and wildlife, recreational purposes, and agricultural, industrial and other legitimate uses. Violators of standards will be notified at least 180 days before abatement action is initiated by the Federal government. Before this would take place, the States would have to demonstrate an inability to secure abatement on their own."

It is unfortunate that space will not permit the inclusion of the complete text of Mr. Poston's address. The selected excerpts, however, carry home his well chosen closing remarks:

"Above all, we see the need for renewed interest, awareness and involvement in our community, State and Federal programs. Our public representatives must receive our backing and support in enforcing the standards and laws when special interests endanger the

public rights. Many of us will have to abandon old prejudices over jurisdictions and roles so that we can all complement each other in this tremendous challenge. My office is open--as, I am sure, are the State and city offices--to anyone who wishes to review our information and examine the alternatives, or just to talk about the job that must be done. I look forward to your help in the successful program for clean water."

Yes, water pollution control is every citizen's business just as surely as clean water is his birthright. Each of us owes his total support to his fellow Alaskans in the abatement of pollution of Alaska's waters.

Reprints of Mr. Poston's complete address are available upon request at: Department of Health and Welfare, Pouch H, Juneau, Alaska 99801.

## MENTAL HEALTH CLINICS

Sub-clinics for extending mental health services into more communities are being planned for both the Southeastern and South-central regions of Alaska.

Psychiatrists from the regional clinics with headquarters at Anchorage and Juneau will also serve the sub-clinics, according to plans for the programs.

Present plans for the Ketchikan sub-clinic call for a resident psychiatric social worker and a clerk typist, with potential development of the services in cooperation with the community. Kodiak would have a resident psychologist and clerk typist.

## MEASLES CASES DROP

Measles cases reported in Alaska from January 1 through September 15, 1967 show about a 75 per cent drop from the number reported for the same period of the previous



year. The 1966 incidence reported was 508 cases as compared with 140 cases for the same period in 1967. These are cases of red measles (rubeola) against which a new vaccine has been used on a statewide immunization campaign during the past 18 months, according to Alaska Department of Health and Welfare records.

The Department's premise is that measles can be eradicated now that a vaccine has been developed which gives lifelong immunity to this serious disease. It is known that measles can be fatal; it can cause permanent hearing damage; and it can result in mental retardation.

It is recommended that all children have the protection of measles immunization which may be received from private physicians and at Public Health Clinics.

## DROWNINGS INCREASE

Alaska, with its "longest coastline in the nation", its thousands of miles of rivers, and countless inland lakes, has a higher rate of deaths by drowning than any other part of the country.

The average rate of deaths from this cause

for 1962-66 in Alaska was 21.5 per 100,000 as compared with the national rate of 0.8 per 100,000, according to the Bureau of Vital Statistics. The figures include all ages and all races. The rate for Alaska's native peoples was 51.6 as compared with 15.1 per 100,000 for the white population. In addition, the rate of drownings in Alaska not connected with boating was 11.5 per 100,000 for the same period. The native rate was 34.8 and the white rate was 5.9. The U.S. rate for all races was 2.8.

A compilation by the Injury Control Program, U.S. Public Health Service Region Nine, quoted the Metropolitan Life Insurance Company Statistical Bulletin for June, 1967 as follows:

"About four fifths of all fatalities in water transportation accidents, numbering some 1,200 a year, result from drownings involving small boats--watercraft propelled by a small motor or sail, a paddle, or oars, and with a passenger capacity of less than 10. About an additional 100 deaths annually are attributed to drownings associated with larger watercraft. The remaining deaths--about one per cent of the total--result largely from falls, explosions and fires, machinery accidents, and asphyxiation by gas while in a boat.



# ALASKA STATE MEDICAL ASSOCIATION ANNUAL CONVENTION PROGRAM

## June 5-8, 1968 Anchorage

### TUESDAY EVENING, JUNE 4TH

8:00 - 10:00 PRE-REGISTRATION AND EXHIBIT PREPARATION

### WEDNESDAY MORNING, JUNE 5TH

8:00 - 8:30 REGISTRATION, COFFEE AND DONUTS

8:30 - 10:30 BUSINESS SESSION - HOUSE OF DELEGATES

10:30 - 11:00 COFFEE, DONUTS AND EXHIBITS

11:00 - 11:30 THE PRESENT USE OF PARAMEDICAL PERSONNEL IN PROVIDING HEALTH CARE TO CHILDREN

Henry K. Silver, M.D., *Professor*  
*Department of Pediatrics*  
*University of Colorado*

11:30 - 12:00 CONTINUING EDUCATION IN PSYCHIATRY

Hugh Carmichael, M.D., *Director*  
*Office of Continuing Education for Psychiatrists*  
*American Psychiatric Association*

12:00 - 1:30 LUNCH, COMMITTEE MEETINGS AND EXHIBITS

### WEDNESDAY AFTERNOON, JUNE 5TH

1:30 - 2:00 YOU YOUNG FELLOWS ORDER TOO MUCH LAB WORK

Robert A. Fouty, M.D., *Assistant Professor, Pathology*  
*Director of Laboratories, University of Washington*  
*King County Hospital*

2:00 - 2:30 ELECTRO-COAGULATION IN THE TREATMENT OF CARCINOMA, PART I

Clifford C. Franseen, M.D., *Chief of Surgery*  
*New England Deaconess Hospital, Boston*

2:00 - 4:00 WOMEN'S AUXILIARY ANNUAL TEA  
VOYAGER ROOM, CAPTAIN COOK HOTEL

2:30 - 3:00 THE IMPARTIAL MEDICAL-LEGAL PANEL

Carl E. Wasmuth, M.D., *President*  
*American College of Legal Medicine*  
*Chief of Anesthesiology, Cleveland Clinic Foundation*  
*Professor of Law, Cleveland Marshall Law School*

3:00 - 3:30 COFFEE, DONUTS AND EXHIBITS

3:30 - 4:00 CHILD HEALTH CARE - PRESENT AND FUTURE

Henry K. Silver, M.D., *Professor*  
*Department of Pediatrics*  
*University of Colorado*

4:00 - 4:30 THE CANADIAN APPROACH TO MEDICAL LIABILITY

Trenholm L. Fisher, M.D., *Secretary-Treasurer*  
*Canadian Medical Protective Association, Ottawa*

4:30 - 5:00 PROSPECTS IN PSYCHIATRY FOR ALASKA

Carl D. Koutsky, M.D., *Superintendent*  
*Alaska Psychiatric Institute, Anchorage*



WEDNESDAY EVENING, JUNE 5TH

ALASKA CHAPTER, AMERICAN ACADEMY OF GENERAL PRACTICE  
ANNUAL BANQUET

THURSDAY MORNING, JUNE 6TH

- 8:30 - 9:00 COFFEE, DONUTS AND EXHIBITS
- 9:00 - 9:30 MEDICARE IN REVIEW  
Edwin Witkin, M.D., *Chief Medical Officer*  
*Office of Medical Staff, Bureau of Health Insurance*  
*Department of Health and Welfare, Social Security Adm.*  
*Washington, D.C.*
- 9:30 - 10:00 SPEAKER PENDING
- 10:00 - 10:30 ELECTRO-COAGULATION IN THE TREATMENT OF CARCINOMA, PART II  
Clifford C. Franseen, M.D., *Chief of Surgery*  
*New England Deaconess Hospital, Boston*
- 10:00 - WOMEN'S AUXILIARY-BUSINESS MEETING AND ELECTION OF OFFICERS  
EXECUTIVE SUITE, ANCHORAGE-WESTWARD HOTEL
- 10:30 - 11:00 COFFEE, DONUTS AND EXHIBITS
- 11:00 - 11:30 SPEAKER PENDING
- 11:30 - 12:00 THE EPIDEMIOLOGY OF HEART DISEASE  
James M. Hundley, M.D., *Executive Director*  
*Institute of Medical Science*  
*Presbyterian Medical Center, San Francisco*  
*Incoming Executive Director of the American*  
*Heart Association*
- 12:00 - 1:30 LUNCH, COMMITTEE MEETINGS AND EXHIBITS

THURSDAY AFTERNOON, JUNE 6TH

- 1:30 - 3:00 PANEL ON MEDICAL LIABILITY  
James A. Lundquist, M.D., *ASMA President-elect, Moderator*  
Trenholm L. Fisher, M.D., *Secretary-Treasurer*  
*Canadian Medical Protective Association, Ottawa*  
Lucius D. Hill, M.D., *Past-president, Washington Medical Association*  
Carl E. Wasmuth, M.D., *President, American College of Legal Medicine*
- 3:00 - 3:30 COFFEE, DONUTS AND EXHIBITS
- 3:30 - 4:00 IS YOUR OFFICE LABORATORY A FUTURE ASSET OR A LIABILITY  
Robert A. Fouty, M.D., *Assistant Professor of Pathology*  
*University of Washington, Director of Laboratories*  
*King County Hospital*
- 4:00 - 4:30 GENETIC COUNSELING IN MEDICAL PRACTICE  
Peter T. Rowley, M.D., *Assistant Professor of Medicine*  
*Stanford University School of Medicine, Palo Alto*
- 4:30 - 5:00 CURRENT TRENDS AND FUTURE DEVELOPMENTS IN SURGICAL PRACTICE  
Lucius D. Hill, M.D., *Past-president*  
*Washington State Medical Association*

THURSDAY EVENING, JUNE 6TH

ALASKA HEART ASSOCIATION ANNUAL BANQUET  
ALYESKA SKI LODGE

Featured Speaker: James M. Hundley, M.D., *Executive Director*  
*Institute of Medical Science, Presbyterian Medical Center*  
*San Francisco - Incoming Executive Director of the*  
*American Heart Association*

## FRIDAY MORNING, JUNE 7TH

- 8:00 - 9:00 COMMITTEE MEETINGS
- 8:30 - 9:00 COFFEE, DONUTS AND EXHIBITS
- 9:00 - 10:00 BUSINESS SESSION - HOUSE OF DELEGATES
- 10:00 - 10:30 COFFEE, DONUTS AND EXHIBITS
- 10:30 - 11:00 CURRENT AND FUTURE PROSPECTS OF TUMOR CHEMO-THERAPY  
John R. Hartman, M.D., *Children's Orthopedic Hospital and Medical Center, Seattle*
- 11:00 - 11:30 WHAT YOU SHOULD KNOW ABOUT CHROMOSOME ANALYSIS  
Peter T. Rowley, M.D., *Assistant Professor of Medicine Stanford University School of Medicine, Palo Alto*
- 11:30 - 12:00 THE AMA AND YOU  
Milford O. Rouse, M.D., *President, AMA*
- 12:00 - 1:30 LUNCH, COMMITTEE MEETINGS AND EXHIBITS

## FRIDAY AFTERNOON, JUNE 7TH

- 12:30 - WOMEN'S AUXILIARY-LUNCHEON  
DISCOVERY ROOM, CAPTAIN COOK HOTEL
- 1:30 - 3:00 PANEL ON "FUTURE OF MEDICINE AND GOVERNMENT"  
Robert B. Wilkins, M.D., *President, ASMA, Moderator*  
Milford O. Rouse, M.D., *President, AMA*  
Edwin Witkin, M.D., *Chief Medical Officer Bureau of Health Insurance, Social Security Administration*  
Donald K. Freedman, *Director of Public Health Alaska Department of Health and Welfare*
- 3:00 - 3:30 COFFEE, DONUTS AND EXHIBITS
- 3:30 - 4:00 FAMILY PLANNING, RETROSPECTIVE AND PROSPECTIVE  
Senator Ernest Gruening, M.D.  
*U. S. Senate, Washington, D.C.*
- 4:00 - 4:30 CURRENT AND FUTURE PROSPECTS OF TUMOR IMMUNO-THERAPY  
John R. Hartman, M.D., *Children's Orthopedic Hospital and Medical Center, Seattle*
- 4:30 - 5:00 COMPREHENSIVE HEALTH PLANNING IN ALASKA  
Donald K. Freedman, *Director of Public Health State Department of Health and Welfare*

## FRIDAY EVENING, JUNE 7TH

ALASKA STATE MEDICAL ASSOCIATION ANNUAL BANQUET  
ANCHORAGE-WESTWARD HOTEL  
Featured Speaker: Senator Ernest Gruening, *U. S. Senate Washington, D.C.*

## SATURDAY MORNING, JUNE 8TH

- 8:45 - 9:00 COFFEE AND DONUTS
- 9:00 - 12:00 BUSINESS SESSION - HOUSE OF DELEGATES

## CLOSING



## YOUR ANNUAL CONVENTION—JUNE 5-8

The 1968 ASMA Annual Convention will be held in Anchorage June 5-8. The theme of the 1968 meeting will be "The Future of Medical Practice". A preliminary program is included in this issue for planning purposes, although some titles are not yet confirmed. The several speakers need little further introduction. Suffice it to say that we have been fortunate in obtaining outstanding men to speak at this meeting.

The annual Heart Association Banquet should provide a good opportunity for many to visit the beautiful Alyeska ski resort area. Although snow will likely be available only at the upper levels, there should be enough to cool the happy hour drinks, which this year are being hosted by the Anchorage Medical Society. The Alyeska management has promised to keep the chair lift and bar open to permit maximum enjoyment of the long June

daylight hours. About the food little need be said except that it's the greatest!, including fresh sourdough bread! For those who would rather relax and sing than drive, charter buses will be available for the scenic ride.

Invitations are restricted again this year to spouses, physicians, dentists, other health professionals, drug men, Heart Association members, etc. For further information and especially for early reservations to help planning of supplies and transportation, please contact Bob Allen at the Alaska Heart Association Office, 304 "E" Street, Anchorage.

Turning to the Annual State Medical Association Banquet, where the cocktails will be hosted by the State Medical Association, invitations are again extended to all spouses, physicians, dentists, other health professionals and detail men. Banquet tickets will include a local combo to help wind up the evening with dancing for all. Better bring your wives to this meeting!

"No class of men need friction so much" as physicians; and no class gets less. The daily round of a busy practitioner tends to develop an egoism of a most intense kind to which there is no antidote. The few setbacks are forgotten and mistakes are often buried, and ten years of successful work tends to make a man dogmatic, intolerant of correction, and abominably self-centered. To this mental attitude the medical society is the best corrective and a man misses a good part of his education who does not get knocked about a bit by his colleagues in discussion.

Sir William Osler





ANNUAL MEETING JUNE 5-8, 1968, ANCHORAGE

# ALASKA STATE MEDICAL ASSOCIATION



519 W. 8th Avenue  
Anchorage, Alaska

PRESIDENT  
PRESIDENT-ELECT  
VICE PRESIDENT  
SECRETARY-TREASURER  
EXECUTIVE SECRETARY

ROBERT B. WILKINS, M.D., ANCHORAGE  
JAMES A. LUNDQUIST, M.D., FAIRBANKS  
PETER O. HANSEN, M.D., SOLDOTNA  
ALISTAIR C. CHALMERS, M.D., ANCHORAGE  
ROBERT G. OGDEN, ANCHORAGE

March 7, 1968

Dear Doctors:

As you have read, more than one thousand bills dealing with health were introduced during the first session of the 90th Congress and 53 pieces of legislation dealing with health were considered during the 1967 Alaska Legislature. It is evident that physicians need to become more active in politics. Such activities protect the patient as well as the quality of the practice of medicine.

Congress and our State Legislature need men and women of both political parties who will give responsible and intelligent consideration to programs effecting health care. The Alaska Medical Political Action Committee (ALPAC) and the American Medical Political Action Committee (AMPAC) were formed to evaluate political candidates and to push the candidates who are believed to be most responsive to the objectives of good medicine and public health. Candidates are selected or supported irrespective of party affiliations. Medical political action committees are non-partisan and must remain so.

Alan Homy, M.D., Chairman	Duane Drake, M.D.	Rudy Leong, M.D.
Michael Beirne, M.D., Sec.Trea.	David Ekvall, M.D.	Royce Morgan, M.D.
Carl Beck, M.D.	Elmer Gaede, M.D.	Mrs. Royce Morgan
Robert P. Billings, M.D.	Betty Hunter, M.D.	Mahlon Shoff, M.D.
David Dale, M.D.	Paul Isaak, M.D.	Fred Strauss, M.D.
Paul Dittrich, M.D.	Marcell Jackson, M.D.	Robert B. Wilkins, M.D.
Joy Donelson, Pharmacist	Peter Koeniger, M.D.	

The annual election of ALPAC chairmen will be held at our annual convention in Anchorage June 5-8, 1968.

If you are not now a member of ALPAC and AMPAC, join today by sending \$20. or more to AMPAC-ALPAC, 519 West 8th Avenue, Anchorage, Alaska 99501. If you have any questions regarding the functions of AMPAC-ALPAC, write or call our executive office for information.

Sincerely,

*Robert B. Wilkins*

Robert B. Wilkins, M.D.  
President  
Alaska State Medical Assoc.

RGO/RBW:md



HOUSE RESOLUTION NO. 6—  
"CLARIFICATION OF BOUNDARIES  
BETWEEN PRIVATE AND GOVERNMENT  
RESPONSIBILITIES IN THE PRACTICE  
OF MEDICINE IN ALASKA"

As directed by House Resolution No. 6 passed during the 1967 session of the Alaska Legislature, the Alaska State Medical Association has submitted to the Speaker of the House of Representatives its Public Health Committee's report as follows:

The increasing availability of federal money allocated to specific state and local health programs has broadened public health activity from its preventive and protective concept to include medical care. This is evident in the Greater Anchorage Borough Health Clinics, where the justification for well children conferences, family planning, chest clinics and orthopedic clinics appear to be mainly through availability of funds.

The pre-school examination program in the Greater Anchorage Area has overwhelmingly demonstrated a lack of justification on the basis of poverty or limited private medical resources. Discontinuation of mass examinations at state contracted rate of \$2.50 per pupil but continuing the requirement, now as an individual parental responsibility, has improved the quality of the examination and saved the state a great amount of money. The number of families unable to afford or obtain this examination is amazingly low (probably less than 10 pupils per year).

At the federal level the Alaska Native Health Service continues to be an ever enlarging bureaucratic enigma. A better example of the validity of Parkinson's Law would be difficult to find. As the magnitude of the original problem diminishes, in this case with the overall improvement in native health, the size of the government agency increases. Even the intra office "make work mechanism" has apparently been exceeded as a reason for increased staff and has led to the necessity of broadening the eligible "beneficiaries". Eligibility requirements and standards are apparently an administrative decision and not defined by federal law.

Gross lack of efficiency appears undeniable when the yearly hospital admission rate per bed of the Alaska Native Hospital is compared with that of a private hospital, such as Providence Hospital, both in Anchorage.

The passage of Public Law 89-749, profoundly influences a definitive reply to House Resolution No. 6. Its ultimate answer will be within the context of a comprehensive state health plan, which will reflect the degree of aggressive participation by the private physicians. The law and its amendments provides the opportunity to strengthen the position of private medicine in the midst of increasing public and governmental involvement in medical care and health programs.

At the present time the Comprehensive

Health Advisory Council, which will compose the total comprehensive state health plan, is made up of the following individuals:

Representatives of Public Agencies

J. Scott McDonald Commissioner of Health and Welfare Department of Health and Welfare Pouch H Juneau, Alaska 99801	Robert W. Ward Commissioner of Administration Department of Administration Pouch C Juneau, Alaska 99801
Glen Wilcox, Coordinator Office of Alcoholism Department of Health and Welfare Pouch H Juneau, Alaska 99801	Dr. David Duncan, Medical Director Greater Anchorage Borough Health Department 327 Eagle Street Anchorage, Alaska 99501
Thomas J. Moore, Advisor Commissioner of Labor Department of Labor P. O. Box 1149 Juneau, Alaska 99801	Ralph Matthews, Advisor Director of Vocational Education Department of Education Pouch F Juneau, Alaska 99801

Representatives of Non-governmental Agencies

		Expiration of Term
Gene Morgan 2617 St. Elias Drive Anchorage, Alaska	Consumer	Feb. 1, 1969
Don Craddick 415 Coleman Drive Juneau, Alaska	Consumer	Feb. 1, 1969
Rod Saunders 2931 Yale Drive Anchorage, Alaska	Consumer	Feb. 1, 1969
Lloyd J. Sutton 513 East 25th Street, Apt. 6 Anchorage, Alaska	Consumer	Feb. 1, 1969
Don Berry 210 Aspen Avenue Mendenhaven Juneau, Alaska	Consumer	Feb. 1, 1970
Walter Bremond P. O. Box 0 Soldotna, Alaska	Consumer	Feb. 1, 1969
Mrs. Emily Savage 1517 Birchwood Street Anchorage, Alaska	Consumer	Feb. 1, 1970
Leo Rhode P. O. Box 406 Homer, Alaska	Consumer	Feb. 1, 1970
Rev. William T. Warren 1035 1st Street Fairbanks, Alaska	Mental Health Organization	Feb. 1, 1971
Mrs. Earl Hunter P. O. Box 36 Juneau, Alaska	Alaska TB Association	Feb. 1, 1971
S. Stealey, D.D.S. Fairbanks, Alaska	Dentist	Feb. 1, 1971
Wilma Rhodes Juneau, Alaska	Consumer	Feb. 1, 1971
Robert Wilkins, M.D. 4077 Westwood Drive Anchorage, Alaska	Alaska State Medical Association	Feb. 1, 1971

Mrs. Elva Scott, R.N. 1650 East 27th Avenue Anchorage, Alaska	Local Education	Feb. 1, 1971
Mel Personnett Juneau, Alaska	Civil Defense	Feb. 1, 1971
Mrs. Elsie Havens Blue, R.N. P. O. Box 10225, Klatt Station Anchorage, Alaska	Alaska Hospital Association	Feb. 1, 1971
Joseph Ribar, M.D. Box 1330 Fairbanks, Alaska	Physician	Feb. 1, 1971
Mrs. Orvald Osborne 818 B Street Juneau, Alaska	Mental Retardation Association	Feb. 1, 1971
Mrs. Patricia Rogers, R.N. Fairbanks Health Center 800 Airport Way Fairbanks, Alaska	Fairbanks Health Center	Feb. 1, 1971
Laurence Sullivan Anchorage, Alaska	Consumer (Executive Secretary, Alaska TB Association)	Feb. 1, 1971

As you can see, the membership of the Health Advisory Council is composed primarily of health “consumers”. This council will compose the total health plan for the State of Alaska. The administration of health services is to be, under the law (P.L. 89-749), according to the priorities and instructions included in the comprehensive state health plan. Physicians may have a voice in this state planning by supplying the physician representatives on the health council with ideas and suggestions in the interest of better health for Alaskans.

# PROPOSED BY-LAW CHANGES REQUESTED BY THE ASMA COUNCIL AND PREPARED BY THE ASMA CONSTITUTION AND BY-LAWS COMMITTEE

## Committee Members:

R. Holmes Johnson, M.D., Kodiak,  
Chairman  
Robert H. Shuler, M.D., Sitka  
Edward Spencer, M.D., Sitka



It is proposed that an additional Section be added to Article II, “Sessions of the Association”, as follows:

Section 3. The responsibility for the planning and financing of the Annual Session shall be assumed by the local society having jurisdiction of the region in which is located the city of meeting.

It is proposed that an additional Section be added to Article VIII, “Committees”, as follows:

Section 7. The Medicine and Religion Committee shall consider and report on matters within its jurisdiction upon request of the President or the Council of the Association and shall, in addition, submit such matters as it feels important to the Association for consideration and action.

Article VIII, Section 1, must be changed to include the words, “a Medicine and Religion Committee”, after the words, “an Industrial Accident Committee”, in order to complete the article in view of the addition of Section 7.

It is proposed that the secretary-treasurer be made a member of the Editorial Board of Alaska Medicine. Thus Article XVI, Section 2, final sentence, shall be changed to read, “The President of the State Association and the Secretary-Treasurer shall be ex-officio members of the Board”.

Then, in Article VI, Section 3, the duties of the Secretary-Treasurer must be expanded to insert the following sentence after, “He shall be ex-officio secretary of the Council”: “He shall be an ex-officio member of the Editorial Board of Alaska Medicine”.

These by-law changes will be voted upon at the annual ASMA business meeting during the convention June 5-8, 1968 in Anchorage.



# LEGISLATIVE DIGEST

By Rodman Wilson, M.D.,

*Chairman, ASMA Legislative Committee*

The Second Session of Alaska's Fifth Legislature convened January 22nd at the State Capitol in Juneau. The Alaska State Medical Association's Legislative Committee has established the Association's position on a number of bills that were carried over from the First Session and some that have been introduced during this session. The following is a list of bills that the ASMA has commented on:

## SENATE BILLS

- SB # 10 An Act requiring that the driver's license show the licensee's blood type; and providing for an effective date - By Ziegler - Approved - Currently in Senate Committee on State Affairs - 1/2/67
- SB # 80 An Act relating to the formation of professional corporations; and providing for an effective date. By Senate Judiciary Committee - Approved - Currently in House Commerce and Judiciary Committees - 3/22/67
- SB # 93 An Act providing for the conservation of the air quality of the state and prevention and control of pollution. - By Palmer, Thomas, and B. Phillips - Approved - SB #93 currently in House Committees on Health Welfare and Education and Finance - 2/23/67 - SB #163 currently in Senate Committees on Health, Welfare and Education and Senate Judiciary - 3/2/67
- SB #232 An Act providing for school instruction on the effects of alcohol and narcotics on the human system. - By Thomas - Approved - Currently in Senate Committee on Health, Welfare and Education - 1/22/68
- CSSB#238 An Act relating to the profession of dentistry - By the Rules Committee at the request of the Legislative Council - Opposed - Currently in the Senate Committee on Health, Welfare and Education - 1/23/68. This bill offers little protection to the public from inappropriate general anesthesia by dentists. Protection of the public would best be provided by (a) strong regulation of the dental use of general anesthesia by the Board of Dental Examiners (b) a Dental Board Regulation that every candidate for general anesthesia be examined by a physician (M.D.) before general anesthesia is administered. Such an examination would not necessarily be comprehensive or expensive. In many instances simply a note from the patient's personal physician to a

dentist would be enough to indicate that a physician had considered the matter, based on his medical knowledge of the patient, and approved anesthesia.

## HOUSE BILLS

- HB # 31 An Act relating to drivers' licenses and providing for an effective date. - By Fink, Borer, Beirne, Fritz and Orbeck - Opposed - Currently in House Committee on Finances - 2/8/67
- HB # 68 An Act relating to eyeglasses and sunglasses. - By Fritz - Approved - Currently in Senate Committees on Health, Welfare and Education and Judiciary - 4/1/67
- HB # 74 An Act appropriating to the Department of Health and Welfare funds to cover the cost for material and personnel to perform phenylketonuria screening tests at the state laboratory. - By Fritz - Approved - Currently in House Committee on Finances - 3/2/67
- HB #130 An Act relating to the licensing of physical therapists. - By Beirne and Fritz by request - Approved - Currently in House Committee on Finances - 2/16/67
- HB #132 An Act relating to the membership of the State Medical Board. - By Beirne - Approved - Currently in House Committee on Commerce and Health, Education and Welfare - 2/7/67
- CSHB#178 An Act relating to chemical analysis of blood in prosecutions for driving under the influence of intoxicating liquor. - Original sponsor Beirne; Committee Change by Health, Welfare and Education Committee - Approved with amendments urged to change the minimum level of blood alcohol from .150 per cent to .100 per cent and require actual written consent instead of implied consent at issuance of driver's license - Currently in Senate Judiciary Committee - 4/4/67
- CSHB#207 An Act relating to the physical examination of school children if a person having legal custody objects on religious grounds. - Original sponsor Fink; Committee Change by Health, Welfare and Education Committee - Opposed - Currently in Senate Rules Committee - 1/24/68
- HB #232 An Act relating to special health and education

projects and providing for an effective date. - Original sponsor Beirne; Committee Change by Health, Welfare and Education Committee - Opposed - Currently in House Finance Committee - 3/4/67

HB #273 An Act relating to community health aids. - By Beirne, Fritz, Boardman, Hensley, Hohman, McGill, Sackett, Westdahl and Young - Approved - Currently in House Committee on Health, Welfare and Education - 3/8/67

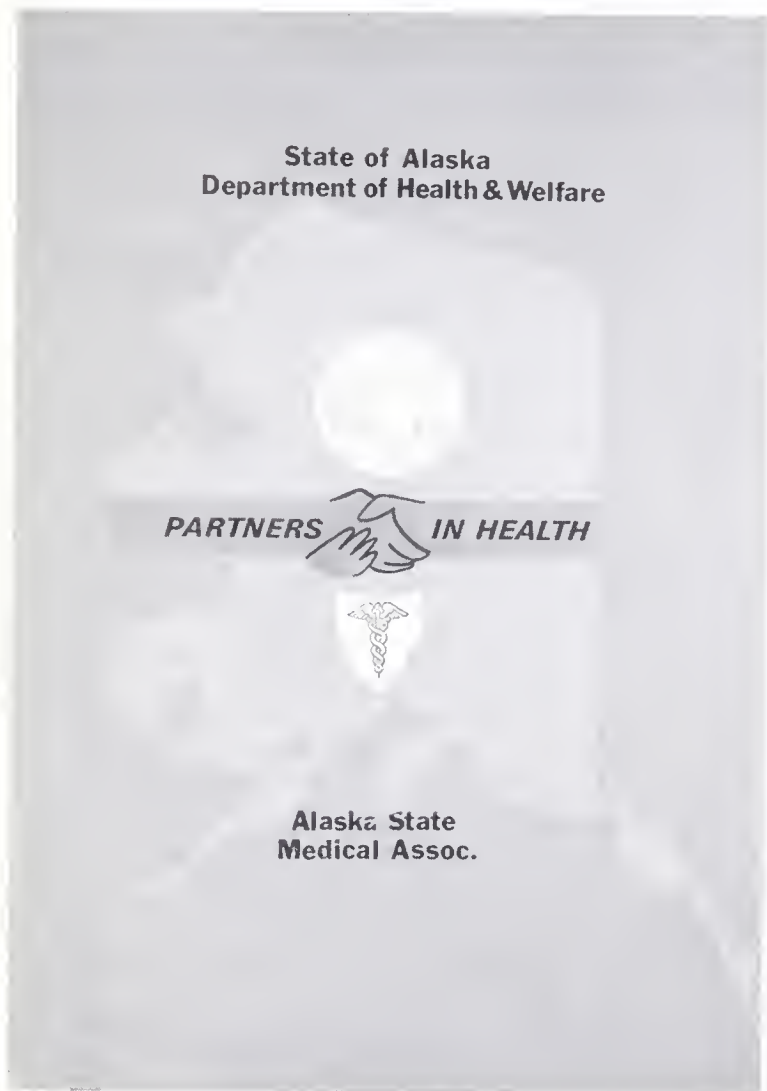
HB #300 An Act relating to reports of injuries to children caused by abuse, neglect or starvation. - By Boardman by request - Opposed because of mandatory reporting requirements - Currently in Senate Judiciary Committee - 4/4/67

HB #327 An Act relating to the regulation of clinical laboratories, blood banks and their personnel; and

providing for an effective date. - By Beirne - Opposed - Currently in House Committee on Finances and Health, Welfare and Education - 3/29/67

HB #369 Acts relating to drug abuse and toxic substances. - 379, 473 #369 by Ray; #379 by Stevens and Ray; #473 by 486, 497 Wiggins; #486 by Harris; #497 by Stevens, Anderson and Banfield - Principles approved with suggestion that the ideas included in the individual bills be covered under one comprehensive act.

HCR #10 Relating to a study of criminal penalties to be made by the Legislative Affairs Agency. - By Judiciary Committee - Approved with the recommendation that this study be completed before passage of bills which specify penalties for particular crimes - Currently in House Judiciary Committee - 2/6/68



## "PARTNERS IN HEALTH" STATEWIDE TV PROGRAM CURRENTLY PROGRAMMED

The Alaska State Medical Association and the Alaska State Department of Health and Welfare are co-sponsoring a statewide television health information program entitled "Partners in Health". This half-hour program is intended to keep Alaskans aware of health service programs and problems, and will be viewed at 10:30 A.M. every other Friday on KTVA, Channel 2, in Anchorage. Program time is donated as a public service by KTVA. These programs will be made available by videotape to other major T.V. stations in Alaska. Herbert James, Jr., M.D., Chairman, ASMA Public Relations Committee (519 West Eighth Avenue, Anchorage), is handling the ASMA portion of the program and Mr. Larry Brown of the Department of Health and Welfare (Community Health Department, 338 Denali Street, Anchorage) is responsible for the State Department of Health and Welfare portion. This program replaces the "You and Your Doctor" program, also on KTVA, which was terminated last spring.



# W/A REGIONAL MEDICAL PROGRAM PROJECTS APPROVED

**By Marion H. Johnson**

*Director of Communications,  
W/A Regional Medical Program*

During his recent visit to Alaska, Dr. Robert Q. Marston, National Director of the Division of Regional Medical Programs, urged Alaskans to use the Regional Medical Program as a catalyst to facilitate a cooperative association among health professions and insti-

tutions appropriate to the needs and resources of their region.

Last February 9th twelve-year-old Gunner Gunderson of Wrangell could have cared less about 'cooperative associations' or heart, cancer and stroke for that matter; he just needed another chance to learn a little more about guns. He will have that chance because his accident happened on the only day that Wrangell ever had two resident surgeons. One of them, Dr. Myles Jones, a Regional Medical Program locum tenens replacement from Seattle, had barely set his feet on the ground when the call came to the home of Dr. David Dale who was at that moment preparing to leave for the University of Colorado to attend continuing education courses. Both surgeons rushed to the Bishop Rowe General Hospital and labored for six hours to repair Gunner's badly torn neck and severed jugular vein. He was given six units of blood.

According to Dr. Dale ... "if either of us had been alone, the boy couldn't have been saved".

Dr. Jones who traded a 290-bed Public Health Service Hospital with its surgical staff of 24 to be the solo-practitioner in Wrangell said that he knew he would have his hands full, but as he put it ... "I didn't expect to have to run from the airplane to the surgery".

This example of 'improved patient care' in Wrangell didn't begin there. Weeks earlier Dr. Henry Akiyama, President of the State Alaska Board Examiners, arranged a special examination to enable Dr. Jones to practice



Dr. Myles C. Jones, Seattle surgeon, was one of the first locum tenens replacements in a Washington/Alaska Regional Medical Program project to enable solo practitioners to seek advanced training in medical centers. Wrangell's solo physician Dr. David Dale was replaced recently by Dr. Jones for three weeks while Dr. Dale continued his medical education in Colorado. A pool of physicians is being organized to provide replacement service to isolated physicians in Alaska. Dr. Jones is assistant chief of surgery at the 290-bed Public Health Service Hospital with a surgical staff of 24.

in Alaska; additional exceptions had to be made to secure malpractice insurance coverage. As long as a year ago, Drs. Bruce Wright, Akiyama, Judge Thomas Stewart and Messrs. James Lanham and George Grimes of Alaska had been attending meetings of the Washington/Alaska Regional Advisory Committee patiently presenting Alaska's 'needs' and 'resources', hammering out a program which would bring the latest in diagnosis and treatment of heart disease, cancer and stroke to their colleagues, and yet not interfere with professional practice or the administration of their hospitals.

Their efforts were rewarded this month when three projects--Anchorage Cancer Program, Southeast Alaska Project and Alaska Medical Library--received funds for operation from a \$1,038,003 grant to the Washington/Alaska Regional Medical Program by the National Institutes of Health.

The Anchorage Cancer Program will provide funds for Alaska's first super-voltage radiation therapy unit; in addition to providing an important therapeutic tool, the installation of the 'cobalt bomb' in Anchorage should serve as a focus for augmenting professional and public education programs regarding cancer in Alaska. The 'cobalt bomb' will not only stimulate interest in cancer detection and therapy, but will strengthen the position of those who have been encouraging the improved data gathering and follow-up of cancer by way of cancer registries and associated programs.

To insure proper use of high voltage equipment in the region, the first full-time radiation physicist consultant will be hired with Regional Medical Program funds.

Now that super-voltage radiation therapy will be available in Alaska for the first time, families of victims will be spared the financial burden that often accompanies prolonged radiation treatment which had been available only at great distances.

Southeast Alaska project will provide

continuing education opportunities never before available to medical personnel scattered throughout this vast region of 79,000 square miles. Continuation of the locum tenens program will be assured with the funding of this project. A pool of physicians is being organized to relieve solo practitioners such as Dr. Dale, so they may continue their medical education outside their local areas.

Physicians in remote areas will be able to discuss their problems and consult with specialists from medical centers in person through an extensive program of hospital staff exchanges. The first staff exchange will be in April when a radiologist from Yakima visits hospitals in Juneau, Sitka and Ketchikan.

Visits by Alaska physicians to the Seattle medical complex will be possible now, and physicians in isolated communities of Alaska will be able to work with physicians in medical facilities nearest them for a week or more. Coronary care training also will be available to hospitals.

Continuing education of physicians, a major part of the Regional Medical Program projects, will be provided in a variety of ways in Alaska. Lectures on heart disease, cancer and stroke by Seattle medical specialists via tele-lecture will be received regularly at St. Ann's Hospital in Juneau, Ketchikan General and Sitka-Mt. Edgecumbe. Funds will be available to experiment with the transmission of EKGs via dataphone.

The Alaska Medical Library project establishes the first complete medical library which will serve all physicians throughout Alaska; and because of its close association with the Northwest Regional Medical Library, Alaskan doctors regardless of their isolation will now have the same reference services and current literature which is available in the largest medical centers.

Letters of authorization from the University of Washington, fiscal agent for the Region-



al Medical Program, were received this month by the respective project directors enabling activities to start immediately.

The next deadline for submitting new project proposals will be May 1. All applications must be approved by a 29-member Regional Advisory Committee, represented by medical professionals and laymen from Alaska and

Washington. Additional details can be secured from Regional Advisory Committee members, Dr. Henry Akiyama and Mr. Lloyd Morley of Juneau and Dr. Bruce Wright and Mr. George Grimes of Anchorage or Dr. Levi Browning, Alaska Coordinator for the Washington/Alaska Regional Medical Program, 322 L Street, Anchorage, Alaska 99501.



# A REVENUE AGENT'S COMMENTS ON RETIREMENT PLANS

(Keogh or HR-10 Plans)

By Charles W. McVay

*Internal Revenue Agent*

Mr. McVay received his Bachelor of Arts Degree from Ohio University, and joined the Internal Revenue Service in 1955. Following eight years with the Portland District Audit Division he joined the Anchorage District office in 1963. He is presently Acting Chief, Audit Division, and has also served as Chief of Review Staff and Chief of Conference Staff.

Professional men in Alaska are showing an increased interest in retirement plans. This is apparent from the number of applications for plan approvals received in recent weeks by the District office of the Internal Revenue Service. This increased interest is largely due to a change in the law which has raised the maximum income tax deduction for retirement plan payments. For 1968 and later years a self-employed person may deduct up to \$2,500 a year for retirement plan payments made for his own benefit. For taxable years beginning before 1968, the maximum deduction was \$1,250.

Prior to 1963, the tax benefits of a qualified retirement plan were not available to the self-employed. Historically, retirement plans were designed for the benefit of employees. The tax benefits given retirement plans by the Internal Revenue Code have been restricted to plans benefiting only employees. In the case of closely held corporations the inclusion of stockholder-employees in retirement plans trespassed, in some measure, upon the principle that proprietary interests were to be excluded from the direct benefits of approved plans. The coverage of stockholder-employees was not unlawful, or necessarily objectionable, but many felt that it did represent an inequity because it gave the

person operating his business in the corporate form an advantage over the person operating his business or profession as a sole proprietor or in a partnership. This apparent inequity was one of the factors leading to the passage of The Self-Employed Retirement Act of 1962. This Act, which is more commonly known as the Keogh Bill or HR-10, extended some of the tax advantages of retirement plan coverage to professional men and other self-employed tax-payers. The Act did this by indirection. Instead of explicitly stating that proprietors and partners were eligible for benefits of qualified plans, it redefined the term "employee" to include self-employed persons.

By the adoption of an officially approved retirement plan, it is possible to postpone the tax on a portion of your income from your productive high income years to lower income retirement years. Specifically, you are permitted a deduction from income for payments into a retirement fund for your own benefit and the earnings of the fund are not taxed until they are withdrawn.

One of the less advantageous aspects of the law is that the plan must also provide coverage, at your expense, for your full-time employees after a qualifying period.

This requirement is consistent with the traditional requirement that qualified plans may not discriminate in favor of corporate officers, shareholders, supervisors or highly paid employees.

Although the law is designed to be generally beneficial to persons adopting a retirement



plan, the advantages will depend upon your particular circumstances. In some cases the tax saving will be substantial. In other cases there may be no tax saving. Some of the factors that should be considered in determining whether a plan will benefit you are your age, income, staffing, expected retirement age and other retirement income. In addition, your interest in the various plans will vary according to your own financial needs and your investment preferences.

In summary, the rules and terms governing self-employed retirement plans are as follows:

**WHO MAY ADOPT PLAN.** Self-employed persons (and partnerships) having earnings from personal services.

**OWNER-EMPLOYEE.** This term refers to the self-employed sole-proprietor, or in the case of a partnership, a partner who owns more than 10% of the interest or profits of the partnership.

**COMMON-LAW EMPLOYEE.** Any individual who under common-law would be considered an employee.

All full-time common-law employees who have completed the required period of employment (never to exceed three years) must be covered by the plan. The cost of this coverage must be paid by the employer. A plan will not qualify if the employees' compensation is reduced to offset contributions to the plan.

**LIMIT ON CONTRIBUTIONS FOR OWNER-EMPLOYEE.** Contributions on behalf of the owner-employee are limited to the lesser of \$2,500 or 10% of earned income.

**ALLOWABLE DEDUCTION.** For taxable years beginning after December 31, 1967, the owner-employee may deduct the full contribution in his own behalf (lesser of \$2,500 or 10% of earned income). Contributions in behalf of employees are also deductible.

**OPTIONAL VOLUNTARY CONTRIBUTIONS.** When the plan covers common-law

employees (or partners with not more than 10% ownership) the plan may permit voluntary contributions by owner-employees up to 10% of earned income so long as the same rate is permitted for other employees.

No deduction is allowable for voluntary contributions. The advantage of voluntary contributions is that their increment is not taxed until the fund is distributed.

**METHODS OF FUNDING.** A qualified plan must be funded. Acceptable funding media are:

1) Annuities and certain insurance contracts.

2) Investment company certificates.

3) United States Retirement Plan Bonds.

4) Mutual fund shares held in bank custodial account.

5) A tax exempt trust created for the plan. A bank must be the trustee. The trust agreement may permit the owner-employee to direct the investments of the trust.

**WHEN WILL FUNDS BE DISTRIBUTED TO SELF-EMPLOYED PERSON.** Except in the case of death or disability, the plan must provide that the self-employed person will be paid no amounts from the fund before he is at least 59 1/2 years of age. Payments to an owner-employee must begin by age 70 1/2. Payments may be made as a lump sum or as periodic payments.

The law imposes an increased tax rate on premature distributions and forbids contributions for the distributee for five years after the premature distribution.

**TAXABILITY OF DISTRIBUTIONS, SELF-EMPLOYED PERSONS.** To the extent distributions represent amounts previously untaxed, they are taxed at ordinary income rates (not at long term capital gain rates) regardless of whether the amounts are received in lump sum or in periodic payments. However, the tax on lump sum distributions is limited to the greater of (a) five times the increase in tax, which would result from including 1/5

of the taxable distribution in gross income or (b) five times the increase in tax which would result if taxable income were equal to 1/5 of the taxable part of the distribution minus personal exemptions.

**COMMON-LAW EMPLOYEES.** In the case of a lump sum distribution upon termination of employment, a common-law employee will be taxed on the distribution at capital gain rates.

The Internal Revenue Code provisions pertaining to self-employed retirement plans are not simple. They are complicated because they are superimposed upon an involved body of law pertaining primarily to corporate employees. This existing body of law was complex because of safeguards against discrimination in favor of highly paid stockholder-employees and safeguards against the

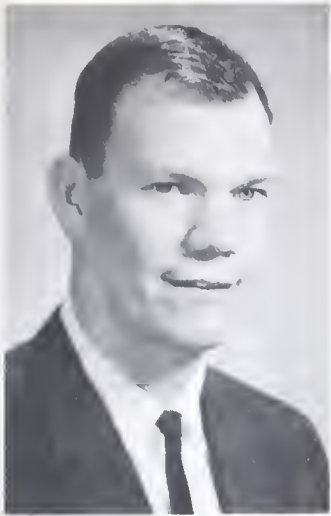
enjoyment of funds before they become taxable.

Because the law is complicated, it would be cumbersome and expensive for each self-employed person to design his own retirement plan. For this reason the use of master or prototype plans has been adopted. These master or prototype plans are plans which have been designed by insurance companies, banks, mutual funds, etc. and approved by the Internal Revenue Service. These previously approved plans can be conveniently adopted by any self-employed person.

The information given in this article is necessarily general. More specific information about the rules pertaining to retirement plans can be obtained by requesting Document No. 5592 from the Internal Revenue Service.







# PERSONAL VIEWS AND ANSWERS ON HR-10 KEOGH PLANS

By A. C. Millet

*Insurance and  
Mutual Fund Agent  
Anchorage*

The Retirement Plan for self-employed persons can pose many questions and be very misleading in its scope and application.

For one thing, there are many vehicles and prototypes available. The most common vehicles are insurance contracts, mutual funds, and bank trustee investment accounts, as well as combinations of these.

The prototypes available allow a formula of fixed percentage, fixed at the start, or fixed percentage combined with a profit option - if income one year drops below a certain level, contributions become optional, or a variable percentage - the percent of contribution is determined yearly by dividing \$2,500 by the income. Example:  $\$2,500/\$50,000 = 5\%$ .

The fully insured plans offer the advantage of guaranteed returns and results as well as the 3 year average rule application. The 3 year average rule states that at the time of inception or change in a plan, you average the past 3 year's income to determine the maximum amount you can contribute to the plan. Then later, your income may drop, but you can still put in the same contribution amount (even in excess of the 10%).

Mutual Funds generally allow more flexibility in their prototype as the investment is amenable to variations in contributions where insurance contracts are usually a fixed contribution. Here we have a portfolio of fully managed stocks. You can select the Fund, and

change it later also, but they do the investing and managing for you. Some things to look for here are: 1. Fund Objectives - do they correspond with your objectives? Example: Growth or Income. 2. Performance - past performance, but more important future possibilities and current performance. 3. Switching - in this day of aggressive funds, switching is not uncommon, some funds allow switching to another fund with no, or only part sales charge. 4. Cumulative discounts - some groups of funds allow a cumulative reduction in sales charge that reduces each year as you reach the reduction plateau. Example: 8.5% \$10,000 to \$25,000 - 6% \$25,000 to \$50,000. 5. Termination - especially early termination of an insured plan can cause substantial loss. Losses are certainly possible in a mutual fund, but at least a large portion of the amount paid in is invested and some value at least is available, even at the earliest termination of an employee or employer. 6. Split-funding - again part can be put into insurance and part into Mutual Funds.

Bank-Trusteed Plans - although at this time there are no qualified approved prototypes as yet in Alaska, some of the banks are just waiting for approval. These plans provide that a fixed percentage formula be used.

From zero to 50% can go into an insurance contract and the balance in an investment account to be fully invested and managed by

the bank as they see fit, according to law, of course.

There has been recent interest in a bank trustee plan where the participant can approve or disapprove the investments made, and thereby manage (indirectly) his own investment portfolio.

After considerable investigation, the outlook here isn't too bright. Although it is legal, there is - 1. No prototype available to my knowledge. 2. A special trust instrument would have to be drawn, meaning attorney fees of \$150 to \$500 or higher. 3. The trust instrument would then need to be approved by the IRS - 6 months to a year is usually required. 4. The trustee bank must accept the trust instrument - a fee of \$100 to \$200 is usually charged for acceptance. 5. The trustee bank would then have to charge a fee for its services of 0.25 to 0.5 of 1% of the assets per year. This fee would be higher if consultation, constant changes, or unusual services were required. 6. You would have to be on your toes to make the investment decisions. Are you qualified? 7. We are only talking of \$2,500 per year - is it worth the trouble and money and time to set up this

arrangement? I think you'll agree that it is not.

Advice - the best approach, in my opinion, to the HR-10, Keogh Plan is to use a prototype that has some flexibility. If you need and want insurance, fine, either split-fund it or fully insure if you like.

If you have enough insurance, then perhaps the investment route is for you. Consider the possible return and the possible risk, explore the Mutual Funds route and compare the risk and performance results with the AMA plan, or the bank prototype. A local representative that can help solve problems and answer questions is certainly a factor also.

Be sure to start out with a low percentage (it can be raised later very easily, but lowering it is another question). Start with a good waiting period, 2 years or longer (you are going to have to live with it for a long time, as it can not be changed later).

In any event get started. It is a tax deductible contribution and the profits are tax-free while under the plan as well. Also you are limited to \$2,500 per year and just because you skip this year does not mean you can double up next year.







## 20th ANNIVERSARY NATIONAL CHILDREN'S DENTAL HEALTH WEEK

By R. A. Smithson, D.D.S.

The first week in February was set aside to observe National Children's Dental Health Week. This idea originated with a small group of men in the Cleveland, Ohio Dental Society, circa 1940, as a local project. It met with such success and acclaim that it soon became a state society project and twenty years ago was proclaimed by the President of the United States as a national observance. The purpose from its inception has been to stress dental health measures to young people and to keep them abreast of the newest developments in the prevention of dental diseases.

We have certainly witnessed many magnificent changes in these past twenty years.

I was a member of the Cleveland Dental Society during those "early days" and knew and admired those men of vision and dedication for their determination to enhance the dental health of the public by simple, straightforward educational measures. Instruction in toothbrushing, emphasis on proper diet, and simple explanations of the process of the disease of dental decay were the mainstays of those first years. In 1949 I held Alaska's first annual Children's Dental Health Day in

Skagway, Alaska. We had a poster contest among the school children, I examined their mouths and talked to them about their dental health, and generally did my best to focus their attention, however, transient it might be, on an important facet of their health. Today, dentists still stress these points, but have modified their talks, lectures, pamphlets and other material to include the applied benefits that dental research has made available. For example, with the millions of Americans now drinking fluoridated water, having FL applied topically to their teeth, and using it in dentifrices, we can eliminate perhaps 80% of the disease of dental decay. Other substances

besides the fluorides are being studied as decay-preventatives. The dental decay process itself is being more clearly understood and defined. One day we shall be able to immunize perfectly against this disease, and that day is not too far distant.

It is significant to note the initiative of private practitioners and their professional organizations in this educational health measure without the benevolent and expensive guidance of governmental agencies. To the dental profession, Children's Dental Health Week is but a single, annual, public manifestation of what is routine private practice in their offices.

## **Southeastern Alaska Dental Seminar**

March 4 and 5 are the dates set for the mid-winter seminar in Juneau. Dr. Charles Bolender, Prosthodontic Department, University of Washington, will lecture on removable partial dentures. He has appeared on two previous programs in Alaska and was well received. Cost of the seminar has been established at \$75.00 plus \$3.50 for a compendium. Checks and reservations are now being accepted by Dr. Robert W. Biggs, Juneau, Southeastern Dental Society President.

## **Progress Report**

This session of the Alaska Legislature will produce bills affecting the dental profession. Many long meetings have been held in Anchorage, Juneau and elsewhere involving the State Dental Board members, SCDDS, Legislative Committee, State Legislators and physicians. The law will have a new look, but should prove to be a very workable, current set of guidelines agreeable and acceptable to all concerned.





# GROW UP SMILING

**By Thomas S. Redmond, D.D.S.**

*Chairman, Southcentral District Dental Society  
for National Children's Dental Health Week*

Remember when nearly every public speaker would open a speech with the same stock phrase? He'd get up in front of the audience, take a deep breath and begin . . . "As I look down at your smiling faces . . .". Well, that expression may be "old hat" now, but as dentists we still enjoy looking down at smiling faces, especially if the teeth behind those smiles are healthy and well cared for. This, of course, is what it is all about. The 20th Anniversary of Children's Dental Health Week . . . February 4 through 10 . . . sponsored by the American Dental Association, its component societies and its members throughout the nation.

The A.D.A. provides us with some startling statistics regarding the nation's dental health:

- \* More than half the people in the nation fail to see their dentist during the year.
- \* About 50% of the children in this country under 15 years of age have never been to a dentist.
- \* Less than one-third of the population brushes their teeth more than once a day. A significant fact in our "rapid pace" society of hasty meals and snack foods of highly refined carbohydrates.
- \* The average two year old has at least one decayed tooth; by the time he reaches 15, he can be expected to have 11 decayed teeth.
- \* Periodontal or gum disease which often begins in childhood is the greatest cause of tooth loss in adults.

The unfortunate aspect of such statistics is that the majority of these dental problems could be vastly reduced with proper care, both at home and in the dental office. Good dental

health habits, as with most habit patterns, are started early in life. A child who has learned the importance of oral hygiene and regular dental care will keep this knowledge when he becomes an adult. Thus, this year our slogan is "grow up smiling" with good dental health.

In the Dental Health Week Program for the Anchorage area, we tried to correct attitudes that contribute to such statistics. The result was a program aimed primarily at the elementary school age group, not specifically to exclude adults, but to reach them indirectly by educating their children. We began by calling attention to the observance of National Children's Dental Health Week with the distribution of posters (the dental wives did this) in some four hundred businesses and offices in the Anchorage area. Radio and television stations gave us excellent coverage by using our (ADA) prepared spot announcements and color slides during their time allotted to public service. The total time given us by radio and television for personal appearances, news interviews, educational films and spot announcements amounted to almost five hours of exposure. Besides this, we had three or four articles with photos in the local newspapers. The Society wishes to extend a very large "thank you" to the news media. We are truly appreciative of their significant contribution of time and effort on the behalf of dental health.

The Arden Farms Company printed the "grow up smiling" dental poster on the side panel of their milk cartons for us, and these were released through retail outlets for their dairy products starting February 4 until the supply of eight thousand was exhausted. The

National Bank of Alaska included miniature posters in their monthly statements to their customers. The Anchorage Telephone Utility also helped distribute these same miniature posters through their offices in the city hall.

These efforts paved the way for our visits to the elementary schools in the Greater Anchorage Area Borough, 31 in all, with a total of 4,498 students reached directly. Each year these school visits are directed at the second and fourth grades. We have used random sampling and statistical techniques to get the most effective coverage of students by our dentists and dental hygienists. The hygienists spoke to the second graders and the dentists to the fourth graders. Presentations were geared to the age group and attention span of the children, and varied somewhat with the

individual making the presentation, but all followed similar formats. Second graders were given a skit showing a visit to the dental office and what is done there. The fourth graders were shown a film on the progress of decay, preventive measures in dental diseases and the importance of a beautiful smile. All of the children were instructed in proper tooth brushing techniques and in the use of disclosing wafers as an adjunct to thorough brushing.

Although this year's efforts in the observance of National Children's Dental Health Week were good, there is much room for improvement. We, therefore, wish to solicit the ideas and assistance of our colleagues throughout the state for a better Dental Health Week next year.





## MEDICAL BRIEFS

# LONG TERM CURE OF A WILM'S TUMOR

By George Hale, M.D., F.A.C.S.

A recent wedding announcement in the newspapers with the picture of a very attractive young woman, now a college senior, reminded me of a pretty four year old girl seen sixteen years ago with a large mass filling the left side of her abdomen.

This previously healthy 4 year old white female entered the hospital one day after her mother noted a left-sided abdominal mass. Physical examination was not remarkable except for a large kidney shaped mass filling the entire left hemi-abdomen, which felt smooth except for one 2.5 cm nodule projecting centrally. The entire mass moved slightly with respiration.

Lab - RBC 3.1 million. WBC 11,000, with 73% poly's and 27% lymphs.

Urine showed 3-5 WBC per high powered field.

Intravenous pyelogram revealed the left kidney pelvis greatly distorted, elongated, and displaced medially and inferiorly by a large mass filling the entire left abdomen, with displacement of the intestines into the right abdomen. The right kidney was normal in configuration and size, and concentrated the dye well.

Chest and skull x-rays were not remarkable.

On admission the patient received a 200 cc whole blood transfusion. The following day,

6-27-51, she underwent a left abdominal exploration and nephrectomy without intraperitoneal spill. There was no evidence of metastasis at surgery. The tumor measured 13 x 8 x 4 cm and appeared largely external to the kidney. On microscopic examination there were large irregular sheets and smaller groups of cells, closely compacted, possessing deeply staining polyhedral to elongate spindle cell nuclei showing numerous mitoses. Final diagnosis was adenomyosarcoma of kidney (Wilm's Tumor) with negative nodes. Her postoperative course was not remarkable. She was discharged on the seventh post-operative day and referred to Seattle for x-ray therapy, where she received 2000 R anteriorly and 2000 R posteriorly (through 15 x 15 cm ports at 400 KV, alternating anterior and posterior fields at the rate of 200 R per day) to the left renal bed and its lymph drainage area.

As far as I have been able to determine, this is the first successful long term cure of Wilm's Tumor in Alaska. A recent complete physical examination on this young woman was entirely negative for signs of recurrent cancer. Other than a well healed left abdominal incision, the only finding relative to her treatment for her tumor is a minimal hypoplasia of the left side of her abdomen and chest compared to the right, which is considered to be a result of the irradiation.



# ULCEROGENIC TUMOR, A CASE REPORT

By Robert S. Smalley, M.D., and Henry Wilde, M.D.

The fact that adenoma of the pancreas can coexist with intractable peptic ulceration of the stomach, duodenum or jejunum was described by Janowitz and Crohn in 1951 and by Forty and Barrett in 1952. Zollinger and Ellison in 1955 reported the association of non beta cell islet adenoma with intractable peptic ulcer disease. Oberhelman and his associates presented a series of six patients where the non-insulin producing cell tumor had arisen within the wall of the duodenum with or without spread to regional lymph nodes. None of these patients had evidence of tumor within the pancreas proper. This group, contrary to that with tumors within the pancreas, had no evidence of associated multiple endocrine adenomata of the parathyroid, pituitary or adrenal glands. The clinical picture in patients with ulcerogenic tumors of the duodenum was characterized by hypersecretion of gastric juice usually with a twelve hour hydrochloric acid yield of 100 mEq or more, peptic ulceration of the stomach, duodenum and occasionally of the jejunum and a long history of treatment for ulcer disease. Diarrhea, steatorrhea and hypokalemia were often associated prominent symptoms. Treatment by surgical procedures for ulcer disease prior to recognition of the tumor was common and uniformly unsuccessful. It is interesting to note that most patients presented a benign clinical course without evidence of metastasis beyond regional nodes. Once the disease was recognized and proper therapy, that is excision of the tumor and its metastases, had been achieved, the cure rate was excellent. It is the purpose of this paper to present an additional case of ulcerogenic tumor of the duodenum that we encountered at St. Ann's Hospital, Juneau, Alaska.

## Case Report

This 38 year old Negro, former paratrooper, presented with hematemesis preceded by one week of severe epigastric pain which was only partly relieved by antacids. He was in good health until 1958 when he was admitted to a Veterans Administration Hospital suffering from acute infectious hepatitis complicated by a duodenal ulcer. The patient has had almost constant ulcer distress since that time. A review of his hospital and clinic charts from elsewhere revealed partial obstruction due to duodenal ulcer disease in 1959 when gastric aspiration yielded an unusually large quantity of highly acid secretion.

Physical examination on admission to St. Ann's Hospital in May of 1962 was unremarkable other than for epigastric tenderness and hyperactive bowel sounds. Hemograms were normal, a VDRL test was non reactive and serum sodium, chloride and potassium levels were within normal limits. A stool was formed and slightly positive for occult blood. Radiographic study of the upper gastro-intestinal tract revealed rapid emptying of the stomach, pseudodiverticuli of the duodenal bulb and a large active posterior crater in the first part of the duodenum. Gastric analysis revealed a large volume of secretions with abundant free acid. The patient was scheduled for gastrectomy with a preoperative diagnosis of severe peptic ulcer disease. This was confirmed at operation and a node-like structure measuring 3 cm in diameter was found immediately adjacent to the common bile duct and the duodenum. It was brown on cut section and rather firm to palpation. A Billroth II subtotal gastrectomy was performed and several other small lymph nodes



were removed from the periduodenal region. No palpable abnormalities were noted within the pancreas or remaining abdomen.

Microscopic examination of the mass revealed a lymph node which was almost completely replaced by an islet cell carcinoma of the pancreas (see figure). Other lymph nodes revealed only reactive hyperplasia. Sections through the portion of stomach removed at operation showed normal mucosal structures.

The patient's postoperative course was excellent with rapid weight gain and no further ulcer distress. He was readmitted approximately two months after his first operation, having gained thirty pounds and feeling well. Laboratory studies revealed a fasting gastric volume of 337 cc with no free acid before or after histamine stimulation. Hemograms, urinalysis, serum electrolytes and stools for occult blood were unremarkable. In view of the microscopic diagnosis of carcinoma and the likelihood that the primary lesion was still within the wall of the duodenal stump or head of the pancreas, it was decided to re-explore the patient and perform a pancreaticoduodenectomy. 9 cm of pancreas and the duodenum were resected along with an incidental cholecystectomy. The tail of the pancreas was anastomosed to the open end of the jejunum. Biliary continuity was reestablished by connecting the common bile duct to the wall of the jejunum. The patient tolerated the procedure well but the postoperative course was complicated by pneumonitis, by formation of ascitic fluid requiring paracentesis of 3,000 cc of a transudate and by a prolonged hospital course with weight loss of thirty pounds.

Microscopic examination of the resected pancreas and duodenum revealed no further evidence of islet cell tumor or hyperplasia.

The patient has done extremely well in the 4 years since surgery. He regained the weight loss following pancreaticoduodenectomy, has formed stools without fat intolerance, is fully employed and the star of a local basketball

team. Routine blood studies including serum electrolytes, a glucose tolerance curve and liver function tests have all been consistently normal.

### Discussion

Our patient presented with a four year history of intractable ulcer disease with a large volume of gastric secretion. This led to occasional vomiting of copious quantities of gastric juice suggesting partial pyloric obstruction. He was submitted to subtotal gastrectomy and the islet cell carcinoma metastasis was found incidentally. Removal of the metastatic node resulted in an apparent cure. Our case resembles case 2 of Oberhelman which demonstrated metastatic lymph nodes adjacent to a microscopically small islet cell carcinoma within the wall of the duodenum. We feel that it is quite possible that the primary carcinoma in our patient was within the wall of the duodenum even though repeat examination of the surgical specimen failed to demonstrate the lesion. Once the nature of the tumor within the node was recognized it was felt that pancreaticoduodenectomy was mandatory even though the course of the patient revealed no evidence of remaining ulcerogenic tumor. Previous authors have recognized the slow rate of growth in these tumors and it is possible that it may be best to treat instances of ulcerogenic tumor of the duodenum by simple excision of the tumor without concomitant gastric surgery. This would apply particularly to instances where the tumor is found within the wall of the duodenum and where it is thought to be an adenoma without lymph node metastasis. It is suggested that the syndrome of ulcerogenic tumor of the duodenum is a clinical entity separate from the cases described by Zollinger and Ellison where the adenoma or carcinoma is within the pancreas proper. Ulcerogenic tumor of the duodenum

seem to be rarely if ever associated with other endocrine adenomata. The disease should be suspected in ulcer patients with a large volume of gastric secretion and an unusually high amount of hydrochloric acid content and in patients where recurrence of ulcer disease and acid secretion occurs after adequate surgical treatment. It is impressive how proper surgical treatment will yield very worthwhile therapeutic results even in cases where node metastasis has been demonstrated.

### Summary

A case of ulcerogenic tumor metastatic to a regional duodenal lymph node in a young Negro male has been presented. The patient underwent subtotal gastrectomy with removal of the involved node, followed by apparent cure of ulcer disease. A Whipple operation was, nevertheless, carried out since residual tumor of the duodenum or head of the pancreas could not be ruled out. The primary tumor was never found, but it is suspected that it was of microscopic size and that it resided in the wall of the resected duodenum. The patient made a complete recovery and is asymptomatic four years later.

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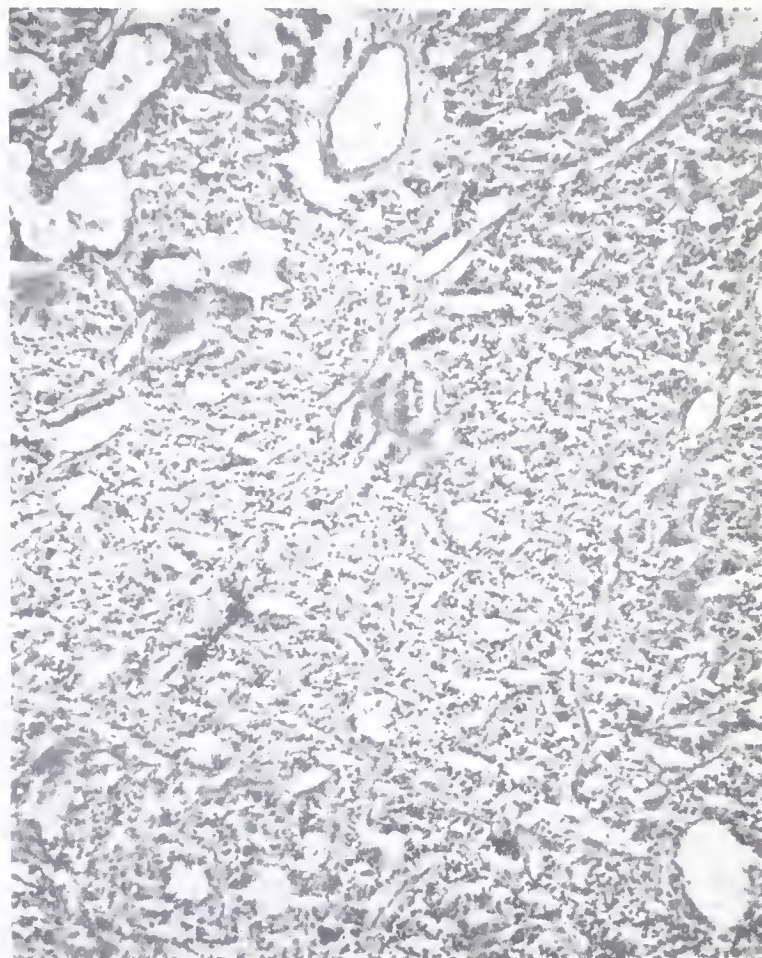
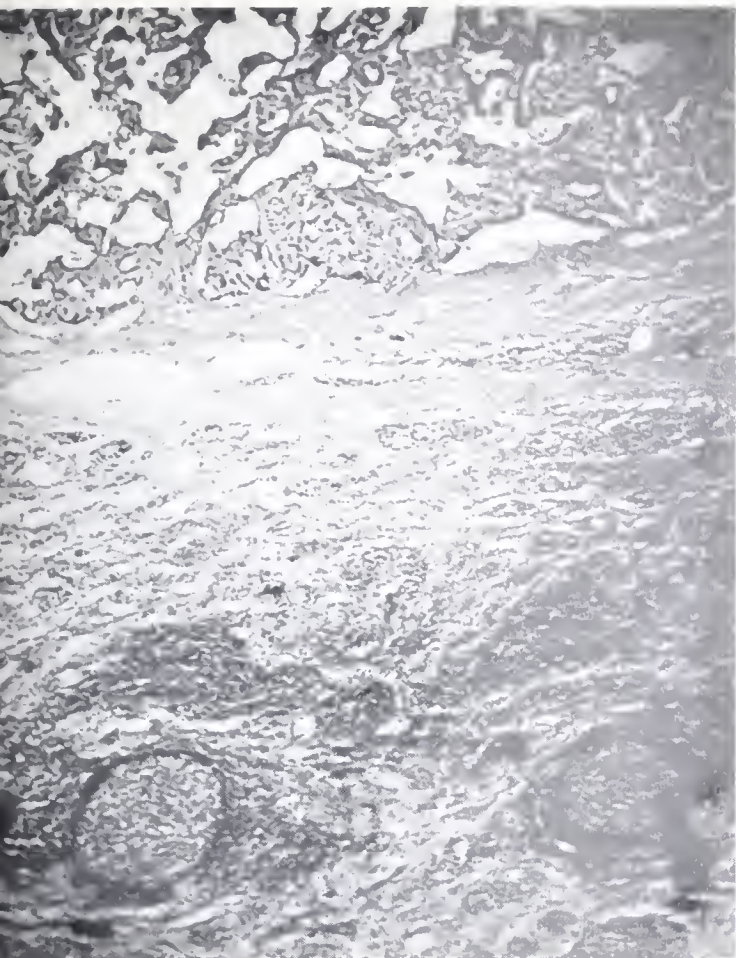
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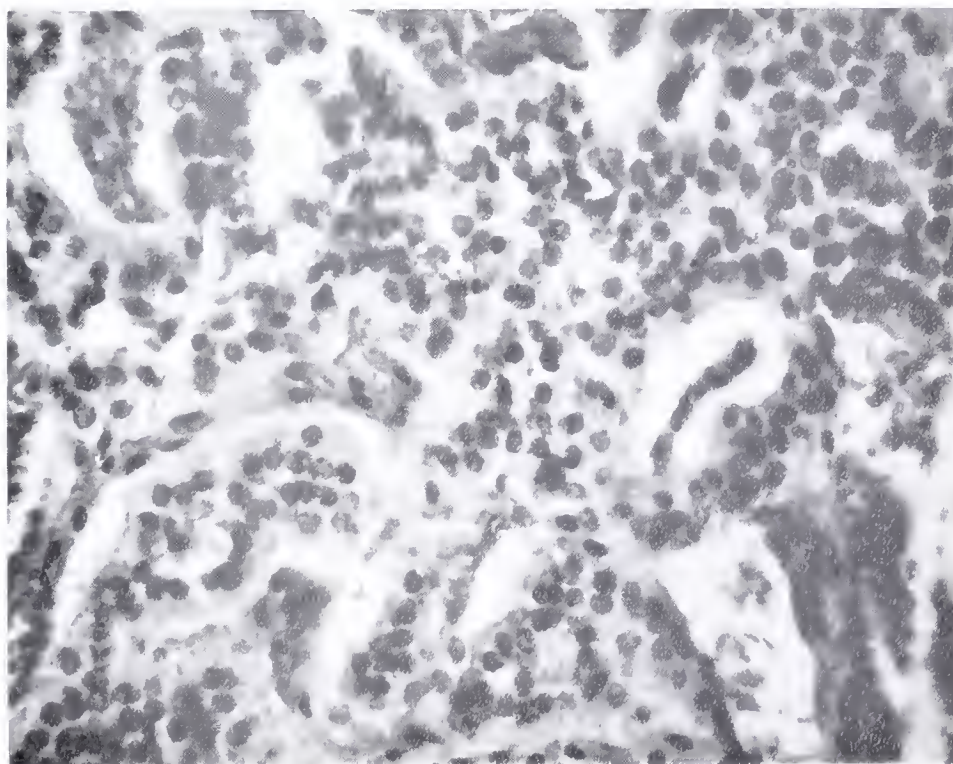
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Sections through resected periduodenal lymph node revealing clusters of islet cell carcinoma.





# MUSHROOM POISONING IN ALASKA

## HELVELLA

By Phyllis E. Kempton and Virginia L. Wells

*Anchorage*

Mrs. Kempton, a 27 year resident of Alaska, attended Washington State University and is a member of the Mycological Society of America, North American Mycological Association, American Institute of Biological Science, and the Arctic Institute of North America.

Mrs. Wells, a 22 year resident of Alaska, attended Willamette University in Salem, Oregon, and is a member of the Mycological Society of America and the Oregon Mycological Society. As a professional photographer, she has also contributed photographs and articles to such magazines as National Geographic.

In their joint studies of the fleshy fungi of Alaska since 1958, they have built up a private library of North American and European mycological literature, and an herbarium of approximately 10,000 collections representing about 500 species.

Mushroom poisoning is not a serious problem in Alaska but when it does happen, it can be frightening as well as dangerous for the victim and baffling for the physician because of its infrequent occurrence and poor documentation. We have previously (7, 8, 9) reported cases of mushroom poisoning from Alaska and have been asked to report on another case which occurred in August, 1967. Following is an account of the poisoning as related to us by Mrs. V. B. of Anchorage.

"On a weekend in August, my husband and I discovered a lot of mushrooms growing in an old plowed field near Wasilla. They looked like a 'Red Beefsteak' mushroom my husband had eaten while living in Illinois so we gathered some of them and I prepared them for dinner by sauteing them in butter. We only had about two large tablespoons of them after they were cooked so I let my husband test them. He said they were so delicious that he would like to find more.

"The following weekend, we found large patches of the same mushroom along the new Knik road out of Wasilla. They were growing in the soil and on rotten wood all along a cleared area where a pole line had been put through recently. We gathered quite a lot of them and had them, smothered in butter, over steak for our dinner that evening. Before dinner, my husband had one can of beer out of which I had just a sip. We ate at 8:30 and I had a cup of the cooked mushrooms, but my husband thought they were so delicious that he must have had about two cups of them. We went to bed early, about 9:30, as he was going moose hunting in the morning. After a couple hours of sleep, I woke up with severe 'charlie-horses' in the calves and upper parts of both my legs. These muscle cramps occurred every few minutes but my husband seemed to be sleeping peacefully. About 3:30 in the morning I couldn't stand it any longer so I called my husband to get up to go hunting. I hadn't had any rest so decided to stay in bed a little longer. He got up but when he tried to stand he complained of being very dizzy and of having trouble seeing. His face was very white. He managed to get dressed but was getting weaker and sicker by the minute. He could hardly move his legs and didn't seem to have any control of his muscles. He asked me to get up to see how I felt and if I acted the same, we should try to get to a doctor as we might be poisoned from the mushrooms we had eaten. While I was dressing, he managed to get outside the camp-



er into the fresh air even though he was very wobbly on his feet. I got him a glass of milk and he started vomiting and had an attack of diarrhea. By this time, all he could see was jagged flashes of light in front of his eyes. I was slightly dizzy and drowsy and had a terrible headache but I managed to drive us back to Anchorage.

“By the time we got home, we both felt a little better and the color was coming back into our faces so we decided no doctor was needed. We went right to bed and slept until about three in the afternoon when I got up and fixed us some chicken broth which seemed to help a little. Later that evening we had some ice cream and went back to bed as we were still very weak. The next morning we still had terrific headaches and upset stomachs but were thankful that we were still alive”.



Fig. 1 *Helvella infula*

The mushroom involved in this case was *Helvella infula* (fig 1) which is 2-4 inches tall and is characterized by a two to four-lobed, saddle-shaped, brittle cap which varies in color from yellow-brown through chestnut-brown to dark brown. The surface is usually smooth when young becoming rugosely wrinkled with maturity. The stalk is tinged with the cap color though usually much paler, and is ribbed or in-

dented near the apex. It is often common in Alaska during August and September.

Little is known about the edibility of *H. infula*. Some authors claim that it is an edible mushroom while others believe that it is poisonous to some but edible for most people. After hearing of Mrs. B's experience, we can only recommend that *H. infula* be avoided for food.



Fig. 2 *Helvella esculenta*

A closely related species, *Helvella esculenta* (fig 2) is also common in Alaska but occurs during May and June. The cap of *H. esculenta* is also brittle, about the same color as that of *H. infula* but, rather than being saddle-shaped, it is more globose, usually much more wrinkled or cerebriform, and larger.

There are well documented cases of poisoning and deaths caused by *H. esculenta* but in spite of this, reports about this fungus are contradictory. Some people have been known to eat this mushroom regularly for a number of years without experiencing any ill effects while others, who also have eaten it regularly for some time, have unaccountably been poisoned. Some mycologists attribute these occasional cases of poisoning to the fact that old or partially spoiled mushrooms have been eaten, main-

taining that the chemical composition of old receptacles has been so transformed that they become poisonous and injurious to health. Other mycologists and physicians ascribe the poisoning to the heightened sensitivity of some persons to certain substances, much the same as an allergic reaction. So far, we have not heard of any case of poisoning by H. esculenta in Alaska but the fact remains that those who use this fungus for food are taking a considerable risk.

Helvellic acid, which is capable of destroying the red blood corpuscles, has been isolated from H. esculenta and, for a long time, was thought to be the only toxic substance in it. Dr. Varro Tyler (3) of the College of Pharmacy, University of Washington, reports that the true poison is a protoplasmic one having a destructive effect on the liver and other vital organs. Its chemical composition is unknown and many of its features are poorly understood. The toxic agent is apparently soluble in boiling water and it is said that in Europe these mushrooms are sometimes rendered edible

by repeated treatments with boiling water. Drying is also supposed to reduce the toxicity although this is a slow process requiring as long as six months for complete destruction of the active principle.

According to Dr. Tyler, the latent period between the consumption of mushrooms and the onset of symptoms is rarely less than two hours and is more commonly six to eight hours. The symptoms are a feeling of fullness in the stomach followed by violent vomiting and watery diarrhea which may persist for one or two days. Headache, lassitude, cramps, and severe pain in the liver and gastric region are followed by jaundice. In severe cases the patient undergoes general collapse, the pulse becomes irregular, breathing is difficult and delirium and convulsions occur; death may result from liver damage or heart failure, usually within ten days. The prescribed treatment includes gastric lavage, administration of cathartics, enemas, and forced fluids. Additional care is largely symptomatic and supportive.

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# ON SEVERAL POSSIBLE EXTRAPULMONARY MECHANISMS OF GAS EXCHANGE IN THE NORTHERN SUBARCTIC REGIONS

It has been said that every physician has his own crocks to bear. The least significant occurrence in any man's practice, however, may lead to the most profound conclusions. From time to time we all observe puzzling physiological phenomena that could lead the properly prepared mind on to true discovery and understanding. Just so did Archimedes overflow the tub and Fleming take the sin out of sex.

A recent early morning phone call, received when my mind was cleared of the previous days vapors and at its maximal acuity, did provide an opportunity for several observations that, despite their apparent simplicity and even common nature, I have not heard elsewhere reported.

In view of the great and expensive programs for the study of respiration, hibernation, and constipation as they relate to space travel, I now report these simple observations in the hope that some other mind, properly backed by research grants, can further delve into the respiratory physiology concerned.

## Background Information

The phone did ring severally; the hour was 5 A.M.; the facts here related were independently observed by my bedfellow, who can attest to the entire discourse.

The caller was female, the wife of a moderately deaf postoperative patient of lean habitus. Said patient, having expressed a desire to arise at 4 A.M. to begin the day's intake of calories, had inexplicably remained asleep. This call at 5 A.M. was a des-

perate request for instruction. Should he be permitted to sleep, or should he be returned to the realities of carbohydrate and nitrogen balance?

She began, "My husband is asleep". I decided to quiet her fears by assuring her that indeed this was a common affliction, nay almost universal, and that actually considering the hour, the climate, the quarter of the moon and the daylight saving time presently adhered to, that just so had I been occupied. However, she stopped only for a confirmatory gurgle, and then went on directly to the randomly assorted and but superficially meaningful words and phrases so commonly emitted by the female homo sapiens (proven by actual measure to be longer in jaw and shorter in cranium)...

But I leave the crucial observation. This phone caller did continue to vocalize without pause for 17 minutes, 43 seconds. One might justly at this pause point out that this is not long for a woman to speak uninterruptedly, indeed perhaps less than the average duration to be expected under optimal circumstances. Also that conditions for a monologue were unexcelled, as she had caught surprised and unprepared, a listener so recently in the arms of Morpheus. To this I can only reply that it has been my life long custom to awake with a glad cry, and leap from my companion in the full possession of all my faculties, and that in addition I never permit a caller to get in another word after pausing for breath; and that it is my habit to terminate such calls by abruptly hanging up while I myself am

speaking, in order to simulate an accidental phone disconnection or defect, after which of course, the phone is unplugged from the wall.

What I am trying to say is that she never stopped to breathe for 17 minutes, 43 seconds! The implications of this observation are revolutionary. But, you say, how do you know that she didn't breathe while talking? The only answer that I can give, is that believe me! for this I waited and prayed. And a long silent prayer it was.

But could she not have spoken on both inspiration and expiration? After all, it is well known that certain persons of peculiar physiognomy can whistle their neighbors to distraction by delivering noises from their pucker through both the major phases of respiration. Ah, even so, but the voice on inspiration, even of the most practiced, undergoes a shift in frequency as related by Doppler, to a different timbre and higher note, making such a maneuver instantly apparent to the trained observer. No, I must insist upon it, she spoke easily, steadily, clearly (even with the phone held at a considerable distance), monotonously and nonsensically without pause or apparent effort for the entire period stated. In fact it may well have been much longer if by chance she did not hear the sound of the phone being disconnected. This then is the observation. Perhaps another observer at an earlier time may also have noted such a phenomenon, but he could not have had the modern techniques and grants so necessary for a complete investigation, and thus his observation has passed without record into the mist.

Assuming then that the observation as reported is proven and accepted, what next?

Scientifically we must proceed in orderly steps from

- (1) General implications
- to (2) The theory
- and (3) The experiment
- to (4) The conclusion.

First implications. Since the dawn of time man has used the club as a weapon, while woman has used the voice. The club has been modified into a rifle, plane, bomb and rocket while the voice as a weapon has not changed over thousands of years. Most serious student of the nursery and the opera have felt that the voice, within the limits of breath, has been developed to its offensive peak (as a weapon). Their assumption however, was that the common necessity for breath represented an absolute limitation to any further refinement of this weapon. We can now conclude that this one revolutionary observation has opened an entire new aspect of weaponry and counter offensive agents. Even as other less offensive sounds are presently being tested as riot control agents, so should the entire use of the voice, as an offensive and defensive mode, be reevaluated in the light of these new findings. Certainly the Pentagon should be aware of these observations and their implications. A reprint has also been forwarded to the President

But I digress. A careful consideration of all aspects of this case has made it necessary to prepare several alternate theories for testing.

First a review of the observation. We have here one example, and I have since seen others less marked, of a woman who can not only talk without thinking but also without breathing.

An obvious first thought concerns the actual energy requirement for such activity. Assume that there is little or no friction at the temporomandibular joint, that the dentures are firmly glued in, and that the



jaw muscles are of the high energy phosphate, high myoglobin, flight muscle variety so well studied in the hummingbird breast. Assume also that, as is so often the case, the figure of speech predicts the scientific truth, and that a woman actually "dives into" the conversation. Perhaps then, just as in the "diving response" of the seal, her blood flow is diverted from the non-essential parts to the jaw. The heart beat slows markedly, the carotids contract and the pH center becomes less sensitive to acidosis and anoxia. Assume these facts, all of which are subject to experimental proof. Certainly if a woman under these conditions were allowed to talk herself to death (in a soundproof chamber to protect observers) one could establish general limits beyond which jaw function would be unlikely. Preliminary calculations lead me to believe that this would fall in the 8-10 minute range at best, but certainly a large controlled series is essential, using not just random subjects but proven talkers.

How then to account for the residual viability and prolonged speech? One must consider extrapulmonary possibilities of regeneration of CO<sub>2</sub> into O<sub>2</sub>. Chlorophyll generally has been necessary for the conversion of energy and CO<sub>2</sub> into carbohydrates and O<sub>2</sub>, and it so happens that chlorophyll has more recently been available in toothpaste, gargles, tablets, and soaps. Is it possible that the CO<sub>2</sub> is regenerated on the rapidly moving surfaces of dentures coated with chlorophyll toothpaste - or that a chlorophyll gargle inhaled has expedited O<sub>2</sub> generation? Do the commonly found marsh gases in the large intestine somehow supply the energy needs for the CO<sub>2</sub> to O<sub>2</sub> conversion by ingested chlorophyll tablets, and is this energy and O<sub>2</sub> somehow then transported to the jaw? Recent work with fuel cell concepts provides support for such an alternate mechanism. Certainly, evaluation

of such methods of energy conversion is essential for implantable heart programs and also for space travel. An investigator in this area should be rapidly immersed in new material.

Associated observations should not be neglected. It is a common, almost uniform reaction of those in an anoxic and stale atmosphere (as found in an overdue submarine) to develop severe lethargy and headache. Headache is also a prominent feature in those exposed to the same atmosphere as the advanced talker. That there are some who can survive in such an atmosphere chronically is evidenced by the fact that many of these women have husbands. However these men are typically lethargic and subnormal in size. Frequently they are also deaf, and most die early of hypertension ulcers, alcoholism, coronary occlusion, adrenal atrophy, baldness, and accidents. These runted individuals appear to have adapted to a toxic atmosphere, possibly by development of a more anaerobic metabolic cycle, apparently involving ethanol as a necessary intermediary. That a mutation may have occurred here is suggested by the deafness commonly found in these individuals. Also they rarely reproduce, and never speak unless alone, at which times they can be observed to ferociously attack inanimate objects.

Kymographic studies must be done to further evaluate the activities of the intact jaw with its muscles, isolated of course from all nerves and vessels, and again a statistical approach suggests the need for a number of such preparations. An interesting observation here is the postmortem jaw motion seen for some hours in the occasional such individual. Electron microscopy and radioactive uptake studies are also essential. Also a bell-jar-on-water preparation, containing a telephone and a pure oxygen atmosphere, into which could put

such a woman, would give definitive results. Certainly, if the water did not gradually rise to the top of the jar as she spoke, an analysis of residual air would be conclusive.

We would seem then to be on the verge of a breakthrough giving both hope and fear for the future. But as the scientist we must pursue truth, and resist regulating ourselves

by current ideas of social need, or fears of future weaponry.

Anonymous

Reprints for the interested reader as well as further data and calculations can be obtained by writing to Anonymous, care of Alaska Medicine.



"THE STALK"

*Collection of Mary Lee Council      26 by 32 oil painting on masonite*

This painting depicts an Eskimo dressed for seal hunting with his white cloth covering over his fur parkee, his polar bear section of fur which he uses to cover his face or to muffle the sound as he slides forward on the ice to get a

closer shot at his target. The model for this painting was Achebuk from the village of Unalakleet. For many years Mr. Machetanz used to accompany him on camping and hunting trips.



# HEALTH OF ALASKA NATIVE CHILDREN

By J. Kenneth Fleshman, M.D.

*Chief, Pediatric Service*

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Dr. Fleshman attended the University of Southern California Medical School and interned at the Los Angeles County Hospital. In August, 1959, he was assigned to the USPHS Hospital in Kanakanak, Alaska as medical officer in charge. After two years he was transferred to the USPHS Indian Hospital, Whiteriver, Arizona. He then completed his pediatric residency at Los Angeles Children's Hospital and returned to his present assignment in Anchorage in July, 1965.

It has been traditional to evaluate the level of health of a population by the health of its infants and children. This report documents the progress that has been made in improving the health of the Alaska Native children but also points out the discrepancies that still exist in this group compared with the general U.S. The Alaska Native population is now estimated at near 48,000. Approximately one half of the population is in the pediatric age group, that is, below 15 years of age.

## Pediatric Health Services

Health care for the Alaska Native was delegated by Congress to the Division of Indian Health, USPHS in 1955 and is provided either directly through one of the seven PHS hospitals in Alaska or by contract with private physicians in such places as Kodiak, Wrangell, Nome and Fairbanks. Preventive health services are jointly provided by the USPHS and the public health nurses of the Division of Health, State of Alaska, through a coordinated contract. The Native child is also eligible for State programs such as Crippled Children's Services. USPHS field hospitals at Barrow, Tanana, Kotzebue, Bethel and

Kanakanak are staffed by general practitioners who meet not only the acute medical needs presenting at the hospital but who also make visits periodically to the various villages in their area in order to carry out case finding, health supervision, chronic disease follow-up and health education. The hospitals maintain daily radio contact with the remote villages of their areas, communicating with the Native health aide who is trained to report symptoms and to dispense medication and first aid under medical advice. Mt. Edgecumbe Hospital, with nine physicians including surgeon, pediatrician, and internist, serves the Native population of southeastern Alaska. The Alaska Native Medical Center in Anchorage is now functioning as a 300 bed referral center for these outlying hospitals. The major specialties are represented on the staff, and those which are not, such as neurosurgery, cardiovascular surgery, urology, and neurology are available from consultants in the community. Although the Medical Center is also primarily responsible for Anchorage, the Aleutian Islands and the Kenai area, the majority of patients represent transfers from the previously mentioned field hospitals who need specialty care. The pediatric service at the Medical Center has 90 beds and is staffed by three pediatricians, two Board-certified and one Board-eligible. In addition to providing care, active consultation to the field hospitals in the form of communication by phone and teletype, as well as by direct visits annually, are carried out. The pediatric service is presently associated with the pediatric department at the University of Oregon in an affiliated residency program. Public Health

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Statistics are from the Program Analysis Branch, Alaska Native Health Area Office, Anchorage, unless specific reference is given.

Service physicians are assigned to Portland for pediatric training and Oregon pediatric residents can spend an elective rotation in Anchorage. Faculty members from the University of Oregon Medical School visit Anchorage quarterly to provide consultation and participate in the health program. Three private pediatricians practicing in Anchorage are also active as consultants.

Health Problems

The infant mortality of the Alaska Native, in spite of recent reduction, (Table 1) remains more than twice that of the rest of the United States.

Table 1. INFANT MORTALITY RATE  
(Deaths Per 1,000 Live Births)

	<u>Alaska Native</u>	<u>U.S. (All Races)</u>
1950	100.4	29.2
1960	74.8	26.0
1966	52.5	23.4

A careful evaluation of these deaths indicates that the numbers and causes of deaths in the neonatal period are quite comparable to those of the general U.S. The excess deaths occur postnatally and are related to infectious disease. The infant mortality rates show a great disparity between the various geographic areas of Alaska, with the Natives of the Kuskokwim and Lower Yukon River area showing the highest rates (66/1000 in 1966). The prematurity rate of 7-8% is comparable to that of the general U.S.

The impact of the lowering of the infant mortality can be appreciated from the present population figures. Census figures for 1950 indicate that there were 33,863 Alaska Natives. The figure today is approximately 48,000. The Native birth rate in 1966 was 41/1000, roughly two times the rate of the

general U.S. population. Overall eighty-seven percent of the Native births were in a hospital, although in some areas the rate was as high as 97%. Family planning is available as a part of routine medical care and both oral contraceptives and IUD's are prescribed. Through October 31, 1967, 36.9% or 3,186 out of 8,626 females age 15-44 were enrolled in the family planning program.

The infectious diseases that account for the increased morbidity and mortality of these children are not those preventable by specific immunizations, but rather are those generally related to poor housing, poor hygiene, lack of sanitation and a low level of education. There has been no measles among Alaska Natives for 18 months and immunization levels for this disease as well as for diphtheria, pertussis, tetanus and polio are very high.

Respiratory disease accounts for 15% of total Native hospitalizations and 75% of the infant deaths.<sup>1</sup> In a study of western Eskimo infants,<sup>2</sup> 35% suffered a significant lower respiratory infection before one year of age. In addition to the usual respiratory bacteria, the role of viruses has recently been documented by the Arctic Health Research Laboratory.<sup>3</sup> Pulmonary infections are not only important because of the immediate morbidity and mortality, but also because of the chronic bronchopulmonary damage that occurs. Non-tuberculous bronchiectasis in Native children occurs at a rate four times greater than reported from any other area of the world.<sup>4</sup>

Otitis media occurs with an increased frequency and severity in Native infants. It is estimated that 10-15% of the population suffer from chronic ear infections. In 27 Bethel villages epidemiologic data collected by Arctic Health Research Laboratory showed that 40% of the infants suffered from acute otitis media with purulent otorrhea before one year of age. Hearing loss was found to be directly proportional to the number of episodes of otorrhea and the child who had his



first attack in the first year of life was at a greater risk of future attacks.<sup>5</sup> This early onset of repeated and chronic infections probably explains why tonsillo-adenoidectomies are generally not preventive and have not been an outstanding success. Often draining ears are not reported because parents still do not realize that this is a dangerous pathologic condition. Areas of the State where the Native population is better housed, fed and educated have a much lower incidence of chronic ear infections.

The success of the tuberculosis control program demonstrates what can be achieved through a well designed cooperative State Health Department-USPHS program. The overall Native case rates have dropped from 588.8/100,000 in 1958 to 166.7 in 1967. The Native tuberculosis death rate of 53.8/100,000 in 1958 will be approximately 8/100,000 in 1967 with all of these deaths being due to the late effects of tuberculosis and none being due to uncontrolled bacterial activity. In 1950 the tuberculosis death rate in Native children under the age of 14 was 100 times the national average for that age group. Only one childhood death due to tuberculosis (meningitis) has occurred in the past two years. The best indicator of the lack of new infections is the rate of positive tuberculin reactions. In 1957 80% of the children entering school in western Alaska were positive, whereas in 1967 only 3.7% were reactors.<sup>6</sup>

In the past diarrhea has not been a significant health problem although minor outbreaks of shigellosis and non-specific diarrhea occur at breakup. However, in the spring of 1965 a very virulent strain of pathogenic *E. coli* swept through the Bethel area villages and accounted for over 50 infant deaths (out of

approximately 500 infants 0-18 months at risk).

The number of children with congenital defects is probably not unusual, however, certain unique conditions do exist. Thirteen children with salt-losing congenital adrenal hyperplasia have been reported from southwestern Alaska in the past ten years. A hereditary type of arthrogryposis has affected six families. Metabolic defects such as methemoglobinemia<sup>7</sup> and a high incidence of pseudocholinesterase deficiency in certain villages<sup>8</sup> have been studied. Correctible defects are referred early for care and if appropriate specialists are not available in Alaska, care is provided elsewhere through the State Crippled Children's Services.

Nutritional iron deficiency anemia is a significant health problem in young children, undoubtedly contributing to the occurrence as well as the outcome of infectious disease.<sup>9, 1</sup> Protein or calorie malnutrition does not exist, nor have rickets, scurvy or other nutritional diseases been recognized, although studies have shown the present Native diet to be deficient at times.<sup>10</sup>

The preceding is only a brief sketch of some of the health problems facing the Native child. Many of these children live in severe poverty, in inadequate houses and with total absence of environmental sanitation such as running water or waste disposal. The villages are often many miles away from the medical facility and often isolated for a week or more by bad weather. Only when these factors are corrected will lasting improvement in health occur. In the meantime the pediatric program of the Division of Indian Health-U.S. Public Health Service is aimed at providing the best medical care possible, in addition to close health supervision of the infant and young child, and health education for the parents.

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"TROLLER'S RETREAT"

This painting depicts an Alaskan fisherman stopping to anchor in one of the many coves found in Alaskan waters. The ever present trees of cedar or hemlock along with the rocky

22 by 28 oil painting on masonite

shoreline help form an interesting pattern of dark and light which is aided by the mountains and the sweep of the clouds and sky.



# ON VOCATIONAL REHABILITATION

**By Dale Reeves**

*Chief, Vocational Rehabilitation  
Alaska State Department of Education*

I have often been asked, "What is Vocational Rehabilitation, some form of creeping Socialism?" My reply is that Socialism results in making people more dependent, while Vocational Rehabilitation is designed to help people become independent, productive, and self-sufficient members of society. Let me then describe the program known as Vocational Rehabilitation.

This program began in 1920, following World War I, when it became evident that a number of disabled World War I veterans were not merging back into the work force but rather were remaining dependents of the Government or of their families. It was felt that many of these individuals with orthopedic impairments could be returned to the labor force after appropriate training. States participating in this original program could only provide disabled persons with testing, counselling, and vocational training, or direct help in suitable placement. Then in 1943, Congress amended this Act to permit the states to provide physical restoration services which would improve employability as well as capability for self-care. These physical restoration services included surgical repair, provision of artificial limbs, hearing aids, speech therapy, psycho-therapy,--practically any medical service that might reduce the disabling condition. Obviously these expanded services became available to many who heretofore had not been served. Many individuals with severe disabilities were then able, with appropriate medical treatment, to reduce their disabilities to the extent that they could be trained for suitable employment. As a consequence of the 1965 Amendments to

the Act, the program has been broadened even further, to include treatment for Public Offenders and others with behavioral disorders, who constitute a drain on society. It is obvious that any major disability can reduce productivity, and also, via necessary taxes and voluntary contributions, act as a drain on the wealth of the community, the state, and the nation. In addition to strictly monetary losses that society suffers through dependency of any kind, there are other costs, not so easily accountable, which are very real. These include the loss of creativity of the individual himself and the effect his dependency has on his spouse and children in shaping their attitude towards life and society in general. This is not to mention the family disorganization that frequently ensues as a result of a man's loss of self-confidence and his frustration when unable to resume the normal male role as the bread winner in his family.

Let me explain briefly the approach and general procedures we follow in working with a client. The disabled person can be referred to us from any source whatsoever. It is then our responsibility to determine whether or not he is eligible for the services of our program--that is, does he have a disability (physical, mental, or emotional) which constitutes a substantial vocational handicap. This determination is made by the counselor after evaluating a number of factors. In nearly every case, we secure a general medical examination to grossly assess the nature and extent of the client's health or physical problems, and to alert us to possible secondary disabling conditions which the client himself may not be aware of but which might impinge upon cer-

tain types of vocational planning. This medical information is usually secured from the client's family physician if he has one and is reviewed by our local medical consultant to assist the counselor in assessing the client's work limitations and capacities. If the consultant feels that additional special examinations may be advisable, these are secured from the appropriate medical person, along with recommendations for any treatment indicated.

While these medical examinations are being secured, the counselor is meeting with the client to further assess the client's academic background, potentials, limitations, his work history, what kind of worker he has been in the past, what kinds of skills he has which might be utilized in new employment or commensurate with his remaining physical capacities, and so on. In addition, vocational testing is usually provided to assess the client's interest, learning ability and aptitudes. Once all this information is obtained, analyzed, and discussed with the client, some agreement is reached regarding the vocational objective. This is then cleared with the medical consultant to be sure that the client's condition will not be aggravated by the work in mind. If training is required to prepare for this vocational objective, arrangements are made by the counselor at the nearest appropriate training facility, whether it be in a business college, a vocational school in Tacoma or Seattle, or an on-the-job training program with a local employer. When necessary, our agency may provide tuition, books and supplies, transportation to and from school, and personal maintenance for eligible individuals in training. The counselor provides follow-up supervision to insure that the client is making satisfactory progress towards his vocational goals and to assist him with any problems that might cause the program to fail. Prior to completion of the client's training program, he and the counselor meet to plan a course of job finding. The

counselor advises the client as to ways and means of filing applications, employers to contact, and of job openings that he, the counselor, knows about, but it is still the client's problem. He is encouraged to do as much for himself as possible in regard to resolving this problem. Of course, in those instances where the individual client may have unusual difficulties in communicating with employers and selling himself, the counselor must then take a more direct role in effecting the placement of the client and in providing closer supervision and follow-up of the client on the job until it is assured that his placement has been successful.

This program was funded up until 1966 on a Federal-State matching basis, each providing approximately 50 per cent of the funds made available. In 1965, amendments changed this ratio to 75-25 with the Federal Government providing the larger share. In no sense is this a "give-away program". It demands participation and motivation for change and improvement on the part of the client or else services simply are not provided. We do make mistakes. We do attempt to work with people whose feasibility is questionable, as we would not be doing our job if we just took the easy cases. I think that any counselor in the program, while grumbling occasionally about the lack of funds, lack of rehabilitation facilities, lack of resources in Alaska, and so on, will never be less than enthusiastic about the concept of rehabilitation, and what it can do in helping to meet the needs of disabled citizens in this Great Land.





# AIR POLLUTION IN THE COOK INLET BASIN

**By Clifford P. Judkins, R.S., and James C. Emerson**

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Historically, public health workers have been charged with the unhappy, and sometimes unpopular, responsibility of warning the public of real or potential health hazards. The rapid environmental changes of recent years have provided ample opportunity for such warnings. We must now point out that the people of Alaska and the Cook Inlet Basin in particular, are faced with a potential health hazard, namely air pollution.

Alaskan public health agencies and public health workers have been concerned for several years by the potential air pollution problem in the Cook Inlet Basin. The 1953 eruption of Mt. Spurr in mid-summer, stimulated a study of the Anchorage area by the U.S. Public Health Service. This study and subsequent work have demonstrated certain peculiarities of the Cook Inlet Basin that deserve consideration by those responsible for public health in this Basin.

As far as particulate matter is concerned Anchorage can be regarded as a relatively clean-air city in the winter. In the summer, however, it currently has the heaviest continuous concentration of suspended particulate matter of any North American municipal areas so far studied. In fact, Anchorage had twice the concentration found in the next most heavily polluted city atmosphere. The major portion of this particulate pollution is attributable to volcanic ash and glacial silt deposited over the area in the past. While this particulate pollution does not represent the health hazard of various organic and chemical pollutants in other areas, it does demonstrate

area susceptibility to air pollution. It is axiomatic that the only effective approach to air resources management or air pollution control is through the management of an entire air shed. Management of only a portion of an air shed cannot be effective as long as uncontrolled pollutants from outside sources affect the area. In addition pollutants from within an area under control while not affecting the area itself may unknowingly affect adjacent areas.

The boundaries of the Matanuska-Susitna Borough, the Kenai Peninsula Borough, and the Greater Anchorage Area Borough completely encompass the Cook Inlet Basin air shed. No pollutants from sources within this basin will ever affect areas outside of the basin. No pollutants produced outside of the Cook Inlet Basin could ever affect the area within the basin. The Tri-Borough Air Resources Management District was established to provide for the consistent, contiguous management of the Cook Inlet Basin (see below).

According to studies by the U.S. Weather Bureau, Alaskan Region, a fairly high air pollution potential exists from the meteorological standpoint in the Cook Inlet Basin. In all seasons temperature inversions are common in the Cook Inlet Basin. During temperature inversions cold air is trapped near ground level; the air stagnates and pollutant levels build up; in winter ice fog is often formed. With an increase in air pollutant sources the danger of serious air pollution

incidents during the winter inversion periods will become more pronounced.

Public education is essential if we are to develop an effective air pollution program. At present the majority of the public does not think we have an air pollution problem. Admittedly the air pollution problem in the Cook Inlet Basin is minimal today, but we must act now to preserve our fresh air. The State of Alaska abounds with natural resources including oil, natural gas, coal, pulp timber, iron, limestone, copper, fish, and other resources. Natural gas has been developed and is readily available on the Kenai Peninsula. Oil exploration and development in and around Cook Inlet has been going on steadily for the past six years, and many wells are now producing with many more predicted. Alaska is already one of the top oil producing states in the nation. A small refinery is presently in operation on the Kenai Peninsula. A multi-million dollar ammonia-urea plant is scheduled to start production this coming summer on the Kenai Peninsula. Other plants are being planned. A large iron ore deposit was discovered in the Cook Inlet Basin in 1965 across from the natural gas fields. These deposits on the west side of Cook Inlet near Tuxedni Bay were filed upon by large national firms. Large limestone and coal deposits are accessible via the Alaska Railroad System. Limestone, coal, iron ore, transportation and economic feasibility mean steel mills. Cargo jets now fly from Seattle to Anchorage in three hours, from San Francisco in five hours, and from Chicago in eight hours. One airline has ordered two new Boeing 747 jets to be in service in 1970-1971. This airline claims the new jets will cause a significant reduction in transportation costs. With these transportation advances and the ever-increasing activities of major national firms in exploration and development, mineral filing, and pilot plants; and considering the fact that the Cook Inlet Basin is the transportation center of the

State with its rail system, deep water, all-year ports, airport system, and the metropolitan service center of Anchorage; it becomes obvious that area industrial development and the associated potential for air pollution are not far in the future.

With this potential problem in mind the Tri-Borough Air Resources Management District has been formed. Three separate boroughs (encompassing a total of 39,700 square miles with over 136,000 persons) are involved; the Greater Anchorage Area Borough, the Matanuska-Susitna Borough, and the Kenai Borough.

Resolutions and contracts have been adopted by the legislative bodies of the three boroughs which authorize the Greater Anchorage Area Borough to apply for funds with which to perform the research and studies within the three boroughs necessary to the establishment of air pollution control standards. The program will be developed under the direction of the Greater Anchorage Area Borough Health Department with intra-agency assistance from the Borough's Legal and Planning Departments.

This development project is designed to define the nature, effects and extent of actual and potential air pollution problems within the district, including the identification of the major existing and potential sources of air pollution and the areas and populations affected. The project will be directed by an Engineer who will be assisted by a Sanitarian and a Chemist. The project is unique in that it will be conducted from a preventative rather than a corrective approach. An extremely broad version of the program plan follows:

To categorize or define our existing air quality through sampling and, at the same time, to define the ventilation system of the Tri-Borough District; to, after considering existing and potential development, determine when, where, and what type of additional



emissions may be allowed and which existing sources, (if any), must be reduced; and to draw the line at that point through the adoption and enforcement of borough ordinances.\*

The Tri-Borough District is unprecedented in that, with the exception of a few occasional localized nuisance situations, the people of the area appear to be satisfied with the present air quality within the District. As we sit in our office on this sunny day and look out on the beauty of Mt. McKinley, more than

100 miles distant, yet as clear as the building next door, we cannot but dedicate ourselves to this task of maintaining our present air quality, by accomplishing a preventive air quality program.

\* Three to four years will be required to complete the program outlined, although regulation of emissions will proceed on an interim basis during this time.



No. 1

Typical temperature inversion near Anchorage along Chugach Mts. Emissions from local asphalt-gravel plant entrapped at ground level.



No.2

This picture was taken two and half hours after picture No. 1. Air pollutants have invaded the entire Anchorage area.



No.3

An example of a localized air pollution nuisance. An increase in sources will create serious problems.



No. 4

Air pollution from freighter in Cook Inlet invading residential area.

# INTERSTATE TRAVEL AND SCHOOL ENROLLMENT AFTER ALASKA GOOD FRIDAY EARTHQUAKE

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From prehistoric times earth tremors have produced fear and urge to flee in man. Studies of flight and other human behavior after earthquake are, however, few. The Alaska Good Friday Earthquake of March 27, 1964 afforded an opportunity to measure some of these phenomena.

Quantitative study of the movement of people to and from an area of disaster is ordinarily difficult because routes and modalities of travel are many. In Alaska, however, ways and means of travel are few. No rail or steamship service from damaged areas was available at the time of the earthquake. Only one all-weather road led from Alaska, the Alaska-Canada Highway. The principal transportation from affected areas was by three interstate air carriers. These provided service from heavily damaged Anchorage, the largest city in Alaska, directly to Seattle (1450 miles) or Chicago (2846 miles). One of them also provided bi-weekly service from hard-hit Kodiak non-stop to Seattle (1453 miles). There were also direct air routes between undamaged Fairbanks, Juneau, and Ketchikan and out-of-state points, but residents of damaged areas ordinarily would not have gone to these cities to enplane for departure from Alaska. It was possible, there-

fore, by studying road and air traffic data to estimate and in some instances to count people leaving the state.

## Road Travel

After the earthquake there was a major increase in departures by automobile down the Alaska-Canada Highway. Outbound traffic at the border between Alaska and Canada was roughly the same in March 1963 and March 1964, but it increased by 1404 individuals in April 1964 - almost doubling in the month after the earthquake as compared to the previous year (Table 1).

Table 1

Departures from Alaska of Individuals by Car  
at Beaver Creek, Y.T., Canada

	1963	1964
March	1514	1440
April	1609	3013
May	5206	5783
June	8907	7186



Table 2

Interstate Arrival and Departure of  
Individuals at Anchorage from  
March 21, 1964 to April 30, 1964

	Arrivals	Departures	Gain/Loss
March 21	99	121	— 22
March 22	126	115	+ 11
March 23	104	94	+ 10
March 24	112	103	+ 9
March 25	89	119	— 30
March 26	89	111	— 22
March 27	96	83	+ 13
March 28	371	227	+144
March 29	259	232	+ 27
March 30	231	291	— 60
March 31	221	262	— 41
April 1	213	261	— 48
April 2	171	235	— 64
April 3	166	357	—191
April 4	94	391	—297
April 5	178	263	— 85
April 6	153	147	+ 6
April 7	160	159	+ 1
April 8	131	164	— 33
April 9	129	194	— 65
April 10	136	182	— 46
April 1-20	148*	170*	—217
April 21-30	153*	148*	+ 47

\*Average per day

Twenty-three percent more cars left during the second half of April than in the first half, the peak day of departure being April 18. May departures were 10 percent greater than in the previous year, suggesting further extraordinary egress. By June 1964 departures declined by 20 percent from 1963. Average occupancy per vehicle was 3.3 in April 1963 and 3.2 in April 1964, not suggesting that more families were leaving in 1964 than 1963.

It is known that many military families were allowed to leave Alaska by car in April, May, and June 1964 in advance of ordinary rotation date to ease the shortage of civilian housing. United States Army, Alaska, lists 121 families comprising an estimated 338 individuals as having left Alaska by road over and above normal rotation travel. Most of these were in April 1964.

United States Air Force, with approximately equal strength in Alaska, also released families for early rotation but has not provided data. There is reason to suspect that fewer Air Force families left than Army families (Table 6), but if it is assumed that an equal number were allowed to leave, then 776 individuals, or 55 percent of excess April departures by road could be accounted for by persons traveling at the direction and convenience of the government. The remaining estimated 628 civilians presumably left at their own volition.

#### Air Travel

Anchorage is the hub of interstate air travel. Travel from Anchorage to other states more than doubled in the fortnight following the seismic shock.\* But for the first 2 days of this period arrivals at Anchorage exceeded departures by 171 individuals (Table 2). A significant portion of this gain probably represented individuals hurrying home from out-of-state trips. Thereafter, except for 2 days on which small gains were measured, departures to April 10 exceeded arrivals at Anchorage. From March 30 until April 10 loss of 923 individuals was recorded, or from April 1 to 10, 822. From April 11 to 20 there was additional net loss by air of 217 individuals. From April 21 to 30 there was a gain of 47. The net loss of people in April 1964 by air from Anchorage was 992.

\*The earthquake occurred at 5:36 p.m., March 27, 1964. Evening flights of some airlines were cancelled, but most carriers resumed service on March 28.

Net loss of people was also recorded at Kodiak:

Table 3  
Interstate Air Traffic at Kodiak

	Arrivals	Departures	Loss
March 30-31*	44	61	17
April 1-10	125	158	33
April 11-20	61	103	42
April 21-30	<u>157</u>	<u>190</u>	<u>33</u>
Total	387	512	125

\*There were no interstate flights at Kodiak March 28, 29.

Total loss at Kodiak for the period March 30 to April 30 was 125 people, or for April 108 individuals.

From March 30 to April 20 there was a combined loss of people from Anchorage and Kodiak of 1232 people. In April alone the combined loss was 1100 individuals (Table 4).

Actual loss of people from Alaska after the earthquake was probably two or three times the net loss of 1100, but their numbers can only be surmised. Some Alaskans undoubtedly left and returned before the end of April and would not appear in net loss figures. The spring months bring commercial fishermen and construction workers into the state. In April 1963, for example, 1144 people more arrived by air at Anchorage and Kodiak than departed. Most of these men probably came as usual in April 1964 for much of their

livelihood came from their work in Alaska. Many, however, may have not brought their families in 1964. In addition to these seasonal workers many others came to Alaska in April 1964 specifically because of the earthquake, such as journalists, governmental agency people, Red Cross workers, engineers, geologists, psychologists, and a flood of new construction people anticipating the reconstruction boom. Many of these remained after April, thus further obscuring the true loss of Alaskans in the month. But despite the expected usual influx of seasonal workers and the unexpected entry of individuals who came because of the quake, the state lost 1100 people in a month in which one year previously there had been a gain of 1144 individuals - a difference of 2244 people. This figure is probably nearer the actual loss of residents by air in April following the disaster, but only the 1100 figure is a measured loss.

Departures from the time of the earthquake until the end of June 1964 exceeded departures in the same period in 1963 by 4896 individuals (Table 4). Since only 743 more came from other states to Anchorage and Kodiak by air in this period in 1964 than in 1963, it can be concluded that there was unexpected outflow of approximately 4000 individuals after the earthquake. How many of these were Alaska residents leaving their homes and how many were newsmen, governmental agency people, scientists, etc., who had completed their work within the period is moot. Undamaged Fair-

Table 4  
Interstate Air Traffic at Anchorage and Kodiak  
Passengers Arriving and Departing in Selected Months in 1963 and 1964

	1963							1964							Loss 63-64
	Arrivals			Departures			Gain/Loss	Arrivals			Departures			Gain/Loss	
	Anch	Kod	Total	Anch	Kod	Total		Anch	Kod	Total	Anch	Kod	Total		
March 1-27	3136*	253*	3389	2586*	225*	2811	+ 578	2950	198	3148	3078	225	3303	- 155	- 733
March 28-31	560*	30*	590	454*	34*	488	+ 102	1082	44	1126	1001	61	1062	+ 64	- 38
April	4108	334	4442	3043	255	3298	+1144	4551	343	4894	5543	451	5994	-1100	-2244
May	5955	525	6480	4523	468	4991	+1489	6289	556	6845	5991	488	6479	+ 366	-1123
June	9671x	738	10409	6148x	486	6634	+3775	9028x	771	9799	6318x	454	6772	+3027	- 748
Total	20294	1627	21921	14168	1243	15411	+6510	20950	1714	22664	18853	1454	20307	+2357	-4153
Mar 28-June 30															

\*In part estimated, 1 carrier supplying traffic data by 10-day periods in March 1963 rather than daily.  
xData lacking from 1 airline carrying less than 5% of traffic in previous months.



banks, on the other hand, showed approximately the same excess of arrivals from out-of-state over departures in 1963 (495 persons) as in 1964 (444).

An interesting aspect of the travel pattern is suggested by correlating day-by-day departures (Table 2, Figure 1) with the aftershocks of the earthquake, which plagued Alaskans for many days and weeks following the main disturbance. After-tremors occurred daily and repeatedly. They caused little or no additional damage but were profoundly disturbing psychologically. It may be significant that the peak of air travel out occurred on April 3 and 4, 7 and 8 days after the earthquake. These were days on which particularly sharp jolts were felt. The April 3 aftershock was especially severe. It occurred at noon. People poured from homes and offices. Apparently, many spur-of-the-moment decisions to leave Alaska were made. As one airline office manager commented:

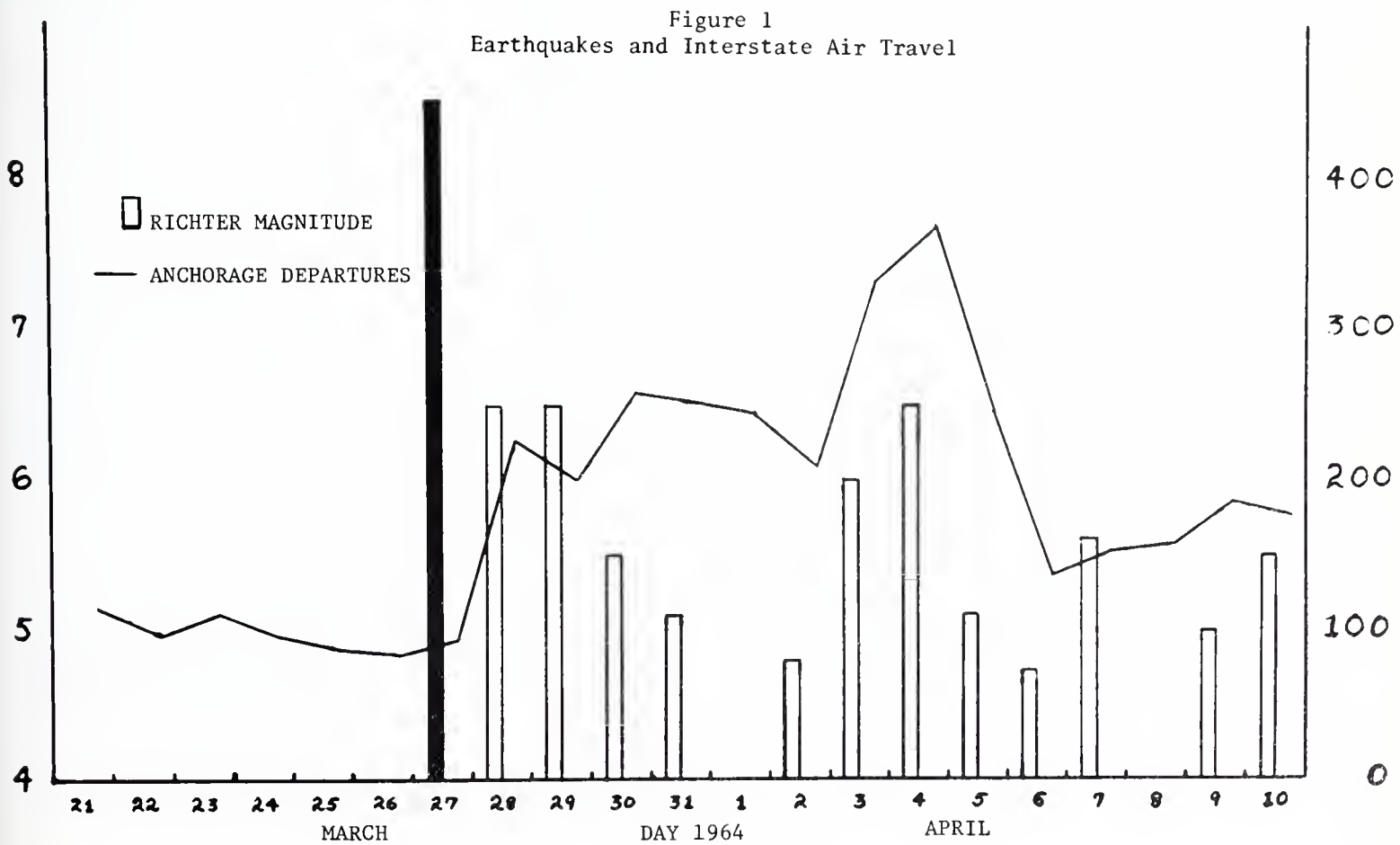
“We had only 30 reservations on our night flight; but after the noon shock the ‘phone

nearly rang off the wall for the rest of the afternoon and evening, and the entire flight filled up.”

A physician traveler that evening commented: “The thing which struck me most, in addition to the confusion and crowding (at the airport), was that a large percentage of the passengers were women and children. The atmosphere was tense and this tension was communicated to the young children who cried continuously during the boarding and the flight.”

No further sharp peaks in departures were observed following this two-day period (Table 2).

If it is assumed that extraordinary departures by road and air from Alaska were by individuals living in heavily damaged Anchorage, Kodiak, Seldovia, Valdez, and Cordova and immediately adjacent areas and not from undamaged portions of the state, then one can estimate percent of loss of Alaskans from affected areas. About half, or 125,000, of Alaska’s 250,000 people including approximately 33,000 military people lived in dam-



aged communities. Loss in April by road and air was calculated to be 2504 individuals. Thus 2 percent of the population was lost in April 1964.

School Enrollment after Earthquake

Further corroboration of the outflow of Alaskans during April is gained by studying public school enrollment in Anchorage. Usually April is the month of peak enrollment as the community is swelled by the arrival of families of seasonal workers.

The 25 schools in Anchorage all sustained damage, but only 3 were destroyed or rendered unusable. Ten grade schools reopened one week after the quake. By double-shifting less-damaged facilities, other schools reconvened by April 10, 2 weeks after the disaster, except for one school which did not reopen until April 14. Shifted students held their original school identity (Table 5).

By the end of April the school system had lost 566 of 16,346 students—3.5 percent of its roster on March 27.\* Withdrawals from schools near shore-line slide areas were largest. The greatest loss, 16.6 percent, was from the Turnagain elementary school in an area where 136 of 687 homes were destroyed. Sixty percent of grade school loss was from grades 1-3. Overall losses were greater from grade schools (4.2%) than from junior high (1.8%) and senior high schools (2.9%) further indicating that families with young children were more apt to leave than those with older children (Table 5).

Further slight losses were recorded up to the final day of school, May 22, 1964, for an overall loss of 632 students or 3.9 percent of pre-quake enrollment. The schools normally lose some students in May as fishermen and others move to summer work positions out of Anchorage.

\*Only one child of school age was killed by the earthquake in Anchorage.

Table 5			
Loss of Students from Anchorage Schools			
School	Enrollment March 27	Students Lost by April 30	Percent Loss
Elementary			
Turnagain, 0.5*	615	102	16.6
Chugach, 0.8	316	38	12.0
Government Hill, 0.6	423	40	9.5
Denali, 1.0	659	45	6.8
Inlet View, 0.4	382	25	6.5
Fairview, 1.8	476	26	5.5
Sand Lake, 2.2	452	23	5.1
Northwood, 1.7	394	19	4.9
Scenic Park, 6.1	397	16	4.0
North Star, 1.3	677	22	3.3
Woodland Park, 1.3	542	14	2.6
Willow Crest, 2.1	552	11	1.9
Creekside Park, 5.1	602	11	1.8
Mountain View, 2.7	479	7	1.5
Williwaw, 2.9	571	6	1.2
Lake Otis, 3.1	718	8	1.1
Abbott Loop, 4.1	407	3	0.7
Rabbit Creek, 1.4	385	0	0.0
Airport Heights, 2.7	516	0	0.0
Nunaka Valley, 4.4	448	0	0.0
	9951	416	4.2
Junior High			
Central, 1.0	1016	42	4.1
Clark, 2.8	1021	13	1.3
Wendler, 3.0	1103	2	0.2
	3140	57	1.8
Senior High			
West Anchorage, 0.7	1672	58	3.5
East Anchorage, 3.7	1583	35	2.3
	3255	93	2.9
Total	16346	566	3.5

\*Distance in miles from shore line.

Students of military families living at Elmendorf Air Force Base and Fort Richardson Army Base adjacent to Anchorage attend base schools through grade 9. High school students in military families attend Anchorage high schools. Enrollment at base schools fell following the earthquake. By April 24 these schools had lost 191 of 4797 students, or 4.0 percent of the March 27 roster (Table 6). Seventy percent of withdrawals were from kindergarten through grade 3 with greatest loss from kindergarten classes.

Buildings were less severely damaged at



Table 6

## Military Base School Losses

Schools	Enrollment March 27	Students Lost by April 24	Percent Loss
Fort Richardson Army	2098	106	5.0
Elmendorf Air Force	2699	85	3.1
Total	4797	191	4.0

the military bases than in Anchorage. The 4.0 percent loss through grade 9 was slightly greater than the combined 3.6 percent loss in Anchorage schools grades 1-9. The higher loss may have been because some military families were directed to leave the state to ease housing shortage as described above or because Anchorage schools have no kindergartens.

In Anchorage school enrollment in the fall was close to pre-earthquake prediction by officials. Of interest is the fact that 294 of 566 students who withdrew in April returned to school in September. Not counting 18 seniors who left in April, 54 percent of April dropouts returned. Two hundred fifty-four students or 46 percent apparently left Anchorage permanently.

In summary, Anchorage schools lost 3.5 percent of students after the earthquake. Military base schools lost 4.0 percent. These percentages are greater than the 2 percent loss of general population calculated to have left by road and air from damaged Alaska communities, but the figures cannot be too closely compared, beyond noting their same range of magnitude, because exactly similar populations are not compared and because of the imponderables listed earlier with respect to loss of general population.

### Discussion

Natural disaster commonly disrupts established modes of transportation and travel. It may also disturb usual methods of measuring traffic. Travel on main roads, the first route of escape from a stricken area, is rarely

counted continuously in any event. Traffic on byways is often never measured. Train and boat travel after catastrophe may not even be counted fully. Air traffic, on the other hand, is regularly and accurately monitored.

Accounts of the mass movement of people after disaster are scarce.\* Many writings are journalistic rather than scientific and their data are often derived from impressions rather than from measurements. Larrabee, for example, writing in *The New Yorker Magazine* about the 1963 Skopje, Yugoslavia earthquake states that, "Immediately after the earthquake Skopje's normal population of around 200,000 fell, it is estimated to 60,000" (2). Or Lowenberg, in a letter to a medical journal describing psychological reactions in the 1952 Bakersfield, California earthquake wrote that, "There has been no exodus to any extent from this community, except for some migratory workers who left in a hurry" (3). Marshall mentioned the precipitous departure of "over one-half" of the guests of one hotel after the 1933 Long Beach, California earthquake and mentions later further departures (4). How valuable such estimates and impressions are is moot.

In a more careful analysis of a different natural disaster Menninger describes the great reluctance of people to leave their homes during a Kansas flood, nearly 3000 of 10,000 homeless having to be rescued or evicted (5). Lachman, Tatsuoka, and Bonk found that only 40 percent of a sample population heeded warnings and evacuated their homes before a tsunami struck Hilo, Hawaii (6).

In Alaska a better chance for assessing mass movement of people after the earthquake existed because of limited avenues of entry and escape and because interstate road and air traffic is continuously counted. A loss in April

\*Much disaster literature is not in general or in medical libraries. The authors have reviewed many articles by title only (1).

1964 of 2504 individuals or 2 percent of the population of afflicted areas was calculated. Loss of students from Anchorage and Anchorage military base schools in April 1964 was in the same range of magnitude, 3.5 percent and 4.0 percent respectively, as the loss in general population. School loss measurements were considerably more precise than road and air traffic losses since individual students were accounted for by name by the schools whereas only net gains or losses were available for air and road traffic as discussed above.

Popular impression, based on news reporting and rumor, was that a great many more Alaskans than 2 percent left the state. Even if 2 or 3 times this number actually departed, the percent of population loss was remarkably low.

But it is impossible to ascertain fully the flow in and out of damaged communities because intrastate movement remains unmeasured. It can be said, however, that except for Eskimos, Indians, and Aleuts, Alaskans generally do not have deep family roots or ancestral homes within Alaska. A resident of Anchorage, for example, was not likely to have fled to undamaged Fairbanks or Juneau. If he left at all, he left the state.

Many newcomers to Alaska, particularly young mothers, who often find climate, housing, and costs difficult, are all-too-ready for an excuse to go "outside". They may well have been the ones who left most readily in the weeks following the disaster. Nonetheless a decision to leave was a major one, if only from a financial standpoint, for travel by automobile involved a trip of several thousand miles and departure by air a trip of at least 1450 miles.

It is difficult to speculate from these data about individual motives for leaving. Many homes were destroyed or damaged, but housing though crowded was somehow contrived for everyone who remained after the earth-

quake. Important shortages of water, food, fuel, medical supplies, or other essentials did not exist. Pestilence, always predicted but seldom occurring after disaster, certainly did not appear in Alaska. It is suggested, therefore, that individuals left more because of discomfort, inconvenience, or for strong emotional reasons rather than because of privation.

No one who has experienced a major seismic disturbance will disagree that fright - profound, primitive fear - grips everyone. Wolfenstein emphasizes this emotion as common to many disasters (7). It sometimes leads to panic and irrational mass flight. This was possibly illustrated in this catastrophe in a surge of departures following a severe aftershock one week after the main disturbance, at a time when many schools and businesses had reopened.

That fear in earthquake can be fatal has been suggested by Lowenberg, who reported the sudden death, unexplained by autopsy, of a 27-year-old woman during an after-temblor (3). In this earthquake a 47-year-old man on a freighter driven by a tidal wave into Valdez, Alaska suffered no visible injury. He died in shock the next day. There was no autopsy, but a federal court in its judicial (if not scientific) wisdom decided that "fear and fear alone" was injury sufficient to cause death in awarding the man's widow a judgment against an insurance company's contention that there was no liability without impact.

But it is far from certain that fear was the only or even the principal reason for leaving the state. Analysis of responses of many individuals during psychiatric interview strongly suggests that many saw in the disaster situation an opportunity to solve personal problems in an "acceptable" way. It was temporarily appropriate to verbalize fear. Fear was used as a reason for leaving even though the true and often subconscious reason was not fright at all. Recognition that



flight was a poor solution to personal problems came quickly to many. They returned from out-of-state within a few days or weeks.

Other psychologic phenomena encountered (and still under study by the authors) were denial, sense of isolation, desire to be near loved ones, conviction of invulnerability, exhilaration, urge to clean up the mess, compulsion to take pictures, need to talk about the quake, and resentment towards sightseers, scientists, and public officials. Some of these strong feelings undoubtedly had bearing on decisions to withdraw children from school or to leave the state.

### Summary

Approximately 2 percent of people in damaged communities left Alaska after the Good Friday Earthquake. School enrollment in Anchorage fell 3.5 percent. Fear and secondary gain rather than privation are thought to have been the principal reasons for leaving.

### Acknowledgment

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# PROMINENT PAINTER CAPTURED BY ALASKA MEDICINE

Fred Machetanz is an Alaskan artist who works in all media but now prefers oil painting and lithography.

He came to Alaska in 1935 with an M.A. and B.A. from Ohio State University to spend six weeks at the Eskimo village of Unalakleet. He has been an Alaskan ever since, devoting all his art to Alaskan subject matter. At the start of his career he had to write books on Alaska so he could illustrate them. Panuck, Eskimo Sled Dog was his first published by Charles Scribner's Sons in 1939. In it, Vilhjalmur Stefansson, the great explorer, said were "the best action pictures of Alaska ever published". In addition, he recommended Machetanz to the Explorers Club on the strength of the book's contribution to knowledge of the North.

With World War II, Machetanz volunteered for duty in the Navy asking for Alaskan service which he received with three out of four years spent in the Aleutians. At the finish of the War, he had the rank of Lieutenant Commander and received a Bronze Star for his work in Naval Intelligence.

Returning to Alaska, he met and married Sara Dunn who took over the writing and now has six books to her credit which Fred

illustrated, all of course on Alaskan subject matter. In 1950 they built a home in the center of Matanuska Valley with logs off of their own land, overlooking a lake in the heart of 2,600 acres of virgin forest. Here they live at "High Ridge" with a son, eight years old, named Traeger after Fred's uncle Charles Traeger who first brought him to Alaska.

Mr. Machetanz's credo of art is that a work of art would be esthetically or dramatically pleasing through the use of color, dark and light pattern and good drawing. So far as possible an artist should experience the subject matter he depicts.

His Master's Degree Thesis was devoted to a study of painting technique which is reflected in his painting. He starts with an underpainting of usually blue and white, sometimes green, first developing pattern and composition in a rather abstract manner. From here he develops his composition realistically with just the one color and white. After this is completed, he then puts on layers of transparent colors or glazes, like thin sheets of colored glass, perhaps seven or eight. This adds the finish color to the painting and completes it. The technique is much like that of the old masters from the renaissance days until the 19th Century when artists became interested in the opaque style or technique of painting. In lithography, Machetanz works on Bavarian limestone in the very same manner that the older artists such as Daumier, Toulouse-Lautrec, Degas and others worked. To date he has done 36 different subjects in limited editions of 100 each. The only complete collection of these is at the University of Alaska Museum.





In 1963 the University of Alaska named him "Distinguished Associate of Art", and in 1966 the Alaska Press Club elected him to their living "Hall of Fame".

His artwork has been acquired by the University of Alaska Museum, Alaska International Art Institute, Explorer's Club of New York, Glenbow Foundation of the Alberta Museum, Canada, the Harold McCracken Collection, and the Northwestern Indian Center of Gonzaga University. One painting takes

Machetanz art to the farthest corners of the earth. It hangs in the library of the "Alpha Helix", University of California's research ship which travels the waters of the world.

Mr. Machetanz has kindly permitted Alaska Medicine to reproduce a number of his paintings as illustrations in forthcoming issues. We hope also to be permitted to present outstanding work by other Alaskan artists in future issues.



# MUKTUK MORSELS

## TOK

Dr. George Cummings Miller of Glasgow, Scotland, who first entered practice in Alaska in 1963 as a member of the Juneau Clinic, and has since practiced in Skagway, Fairbanks, Whitehorse, and Elsa, Y.T., has opened a private office in general practice in Tok.

## FAIRBANKS

With a stunning recovery Fairbanks is essentially back to normal. The few business failures and foreclosures were generally premature rather than unexpected. All medical offices, clinics, and hospitals are back in full swing. There appears little chance that Bassett Army Hospital will be opened for civilian use and discussion now centers about a possible local fund drive to finance the desperately needed new hospital facilities. In the meanwhile the Sisters of Providence still plan to close St. Joseph's Hospital this summer, which will likely result in the community having to purchase or lease this antiquated structure.

Dr. Joseph Ribar attended the AMA semi-annual meeting of the House of Delegates in Houston as the Delegate for Alaska (see Delegate's report).

## SOLDOTNA

Dr. Paul Isaak reports an active general practice preceptorship program again in store for the peninsula this year. He has several physicians planning time off from their residencies in Iowa, including Dr. Elaine Reigel in pediatrics who is coming up for her second tour. Also expected this year are doctors

from Tulane and possibly Colorado. Amazing what can be done without a grant. Speaking of grants, things are apparently more hopeful for completion of the Peninsula General Hospital, and we expect more on this soon.

## KENAI

There is as yet no resident physician in Kenai. Drs. Isaak, Gaede and Hansen, of the Peninsula Medical Center, provide full physician coverage on weekdays at the Kenai Medical Clinic. Also Dr. Calvin Johnson of Anchorage has opened an office in Kenai and works there four mornings a week, in addition to his Anchorage practice.

## SEWARD

Dr. Ernest Gentles has closed his practice and moved to Oregon. Dr. Richard Curtis of Utah, who was stationed at Bassett Army Hospital for two and one half years, has joined Dr. E. A. Watson in general practice.

## ANCHORAGE

Dr. Betty Woods Hunter recently married John A. Ireton of Anchorage. She will retain her former name in her practice. Dr. Sam W. Gibson has opened a private office for the practice of Obstetrics and Gynecology. Dr. Gibson is board certified in Ob-Gyn and was formerly in practice in Eugene, Oregon. Dr. Eldon Maxwell has become associated in a general practice office with Dr. C. F. Nicholas. Dr. Marcell Jackson has joined Dr. Charles F. St. John in his general practice office. Dr. Nancy Sydnam closed her general practice office and moved to Juneau when her husband was transferred from Anchorage.



Mr. Charles Richardson has been replaced as administrator of Anchorage Community Hospital by Mr. Robert O. Burns. Mr. Burns is acting hospital director for Pioneers Associates, the hospital supply and management firm that bought the Presbyterian Hospital. Dr. Alistair Chalmers passed his Canadian boards in urology. Dr. Alan Homy was elected president of the Anchorage Democratic Club. Alaska's American Medical Political Action Committee (AMPAC) which now has 22 members will be represented in a meeting in Washington, D.C., March 9 and 10 by Dr. Alan Homy (Chairman) and Drs. Robert Wilkins, Robert Billings, M. F. Beirne, and Royce Morgan (Delegates). The Alaska-Washington Regional Medical Program plans for purchase of a Cobalt unit to be located at Providence Hospital have been approved and funded. Dr. Bruce Wright and Mr. George Grimes will now spearhead a building fund drive under the auspices of the American Cancer Society to house this much needed unit. In addition another significant need has been met with the Alaska Medical Library Grant approval and funding. This facility will be located at the Alaska Native Medical Center in Anchorage where library work is already in progress, under the direction of Dr. Walter Johnson. In effect the funding will permit expansion of services of an enlarged medical library to all physicians in Alaska on an equal basis.

We have a notice that Dr. Paul S. Clark has been appointed epidemiologic Intelligence Officer for the State and should be contacted on any confirmed case of rubeola as well as any other communicable disease where an epidemiologic investigation appears indi-

cated. (338 Denali Street, Anchorage, or call 272-1401 collect.)

## JUNEAU

The regional medical program communication and medical education grant for Southeastern Alaska has been approved and funded and should be of significance as a pilot project. Under the leadership of Dr. Henry Akiyama a greatly accelerated and regularly scheduled course of clinics and seminars is planned, as well as an EKG hot line program. In addition, locum tenens assistance will be provided while isolated physicians go out for postgraduate training. Under this program Dr. David Dale of Wrangell is presently taking a three weeks postgraduate course in Seattle, while Dr. Miles Jones of Seattle's Public Health Hospital provides medical coverage in Wrangell. This entire program seems to be a well thought out pioneering effort and will be watched with great interest.

Dr. R. Harrison Leer, 48, passed away recently in Seattle shortly after falling ill while on a clinic in Haines. He had just reopened his offices in ophthalmology in Juneau after some years absence.

Dr. Wallace J. Chapman recently resigned his post as Alaskan Commissioner of Health and Welfare. Mr. J. Scott McDonald has been appointed Commissioner of Health and Welfare.

Dr. Donald K. Freedman of California has been appointed Director of Public Health. Dr. Freedman is board certified in Preventive Medicine and has considerable experience in administrative medicine.

# A CLINIC TO ST. MARY'S - 1967

By Milo H. Fritz, M.D.

The 8th annual EENT clinic at St. Mary's was held "at no expense to the government" as the phrase goes, Sunday through Wednesday, September 3-6. One-hundred thirty-two patients were seen. The trip was made in a Northern Consolidated Airline prop jet F 27 from Anchorage; 385 pounds of air freight had been sent ahead and was awaiting us at the Mission.

The trip took a little over one hour which was in great contrast to the usual day or two it takes when we fly our own plane. But what it makes up in efficiency it loses in fun.

The new airstrip is covered with gravel but is still a little too short for the 727's that will be in operation soon.

The Mission itself has improved greatly. There is a wooden warehouse and a boys' dormitory made of prefabricated steel. St. Mary's village, right next to the Mission, is now a second class city with all the responsibility that this implies. The priests at the Mission have deeded the village to its inhabitants so there should be one less land claim on aboriginal rights pending against the state of Alaska.

With me for the clinic was my friend the Guild Optician, John Spahn, who has been helping with them since 1955.

The Mission has about 250 students almost all of whom are Eskimos, though some may be of Indian extraction. The Superior at this time is Father Rene Astruc, S. J. He is assisted by other priests and two lay brothers and a staff of teaching nuns and many lay volunteers from the eastern part of the United States. They act as teachers, help with the cooking, laundry and do other necessary chores, attendant upon the care of 250 active youngsters.

The Mission is a tribute to the human

spirit. Taken bit by bit nothing should work. Of course the place has improved immeasurably since it moved up from Akulurak about 10 years ago when that institution began sinking into the primordial ooze of the lower Yukon.

When I say that the Mission should not work I do not mean that something slovenly or unkempt is being offered to our young people of Western Alaska. I merely mean that taken singly, the lighting system, the heating system and many other physical aspects of the place simply would not pass muster in any city with the most liberal building code. But, of course, the thing that holds it all together is not the wiring, the plumbing or the heating but the human spirit which, in this particular institution, reaches a level of perfection seldom seen.

One of the lay volunteers is James Lee of Anchorage who is a heavy equipment operator. Somewhere along the line Father Astruc acquired a D-8 cat, which has used up eight of its nine lives. The clutches are worn, the sprockets almost smooth and in order to get a pile of dirt in a particular area one has to begin far to the right of where he intends ending up because of the unavoidable predilection this particular piece of heavy equipment has for turning to the left. Still, in spite of this, the excavation for the girls' dormitory is continuing and I have no doubt that when the old vehicle finally breaks down and gives up the ghost, the muscles of the youngsters applied at the handles of shovels will complete what this tired D-8 caterpillar tractor will no longer be able to do.

I examined 132 patients. Three or four of these were white and were members of the staff. The rest were natives. All the eye examinations were done under a cycloplegic, and



101 eyeglasses were prescribed. They are made up by the Physicians Optical Company of which Mr. John Spahn is the owner. He measured all of the youngsters for frames and supplies the glasses at cost plus \$1.00, the extra dollar being used for postage and repairs that are made from time to time on the glasses as the year goes by.

This money has been contributed by patients and other individuals in and outside Alaska who donate to the Eye, Ear, Nose and Throat Foundation of Alaska, Incorporated, started by my wife and me many years ago. A large part of these funds is given each year by an organization of ladies in Short Hills, New Jersey known as New Eyes for the Needy.

In the evenings Mr. Spahn taught the nurses how to dispense spectacles, make adjustments and make repairs and also how to make the buttons that must be custom made for each ear in order that hearing aids may be properly used. The hearing aids that we supply to the youngsters were given to the Foundation by the Zenith Company some years ago.

The prices asked for the glasses of the youngsters is \$6 for single vision and \$8 for bifocals which are occasionally prescribed for elders in the village of St. Mary's. If Father Astruc feels a youngster cannot pay the \$6 or the villager cannot pay the \$8 for bifocals, the Father decides what they can pay and assesses them accordingly. In this way we do not push socialism any further. We make each individual patient financially responsible for the glasses that he receives. True, some of the youngsters don't have any money at all. Under those circumstances Father Astruc prescribes a job of painting or carpentry or something extra by which he can earn the money and therefore, maintain his self-respect while getting the glasses he needs. The hearing aids cost the youngsters \$5 or whatever portion of this fee that Father Astruc decides he can pay.

A large number of the youngsters still

show the scars from repeated attacks of phlyctenulosis (PKC) which gets in its crippling blows before they reach school age.

One case of retinitis pigmentosa was discovered.

The most appalling finding, as usual, was the prevalence of poor hearing from repeated attacks of otitis media and mastoiditis. One man in the village, age 47 had a chronic mastoiditis, still had his tonsils firmly in place and had a facial paralysis as a complication of his mastoiditis. He and a 20 year old girl with what looked like a malignant melanoma of the skin were reported immediately to the Alaska Native Health Service in Anchorage for emergency care. Both were taken into Anchorage within a day or two. Five additional cases of mastoiditis were picked up in the student body where a T & A was still needed! Two cases of mastoiditis, where T & A's had been done, were also reported to the Alaska Native Health Service. There were 21 cases of perforated or badly scarred ear drums where tonsils and adenoids were still in place! These were also reported to the Medical Director of the Alaska Native Health Service for T & A's to be done immediately. There were two cases needing tonsillectomies or T & A's where the condition of these structures by themselves was reason enough for immediate surgery.

When John Spahn was not teaching the nurses, Miss Fauscher and Miss Connor, about spectacles, hearing aids and the preparation of hearing aid buttons, the nurses and I went over the charts of the individual cases seen that day. We discussed such things as removal of foreign bodies from the lids and the cornea, what to do when eyes were injured or when injury was suspected, how to treat chronically discharging ears and other things that increased their usefulness as nurses since they are often the only medical refuge in this area.

One-hundred and one pairs of glasses were

prescribed and two hearing aids will be sent to the Mission.

On the morning of our leaving, Father Astruc, the lay brothers, John Spahn, and I, helped unload the freight from the plane and put the seats in place in order that the students going to schools outside of Alaska could be taken care of. This stimulated the appetite, increased the efficiency of the operation of the Northern Consolidated Airlines F 27 and supplied the senior members of the group at least, with some much needed exercise.

It was great to see the increased physical well-being and the better clothing and general appearance of the student body in general. Some of those who had been dug up from the remote villages for the first time this year, were in as sad need of what could best be described as civilizing as they were in the olden days. But they represent a much smaller per cent of the student body than they used to. These students who have been there two or three years or who have gone through eight years of schooling are as bright eyed and well-

dressed and well-groomed as you would hope to find anywhere in Anchorage or in the south 48. Some of the girls are really beautiful and intelligent and would be a stunning addition to any social or public gathering. All the students represent a great tribute to the industry and devotion of those who have run the Mission. And when I say run the Mission, I mean just that. Nobody directs anything from an office.

There are study halls between 6 and 7 in the morning, and after school closes between 7 and 8 at night, because there is no true library and no room in the crowded dormitories for any studying. That many of these youngsters now are in college and some have graduated, is further tribute to the invaluable character training as well as the formal scholastic education of these youngsters.

It is always a pleasure going to St. Mary's no matter how tired I am because the inspiration of those who run it banishes fatigue and makes me feel that my medical efforts are worthwhile.

## MEETING NOTICES

The first International Symposium on Dextrans will be held at Galveston Island, Texas on Sunday and Monday, May 19 and 20, 1968. Entitled CURRENT CONCEPTS OF THE BASIC ACTIONS OF DEXTRANS AND THEIR CLINICAL APPLICATION IN THE CARDIOVASCULAR AND RELATED FIELDS, the symposium is co-sponsored by the Texas Heart Association, the Council on Circulation of the American Heart Association, the Postgraduate Education Division of the University of Texas Medical Branch, the University of Minnesota Medical School and the Georgia Institute of Technology-Biomedical Division.

Researchers from Europe and the United States who have carried out extensive research studies on the Dextrans for 20 years or more will participate in this important two-day symposium. Program planners advise that the major emphasis of the symposium will be placed on the use of Dextrans in the cardiovascular field.

Programs, advance registration, and hotel reservation forms for the Dextran Symposium may be obtained by writing or calling the Texas Heart Association, P.O. Box 25041, Houston, Texas 77005 - Area Code 713 - Jackson 6-4194.



# REVIEWS OF RECENT BOOKS

SYNOPSIS OF GYNECOLOGY, By Beacham and Beacham. 7th Edition. Mosby, \$8.50.

Synopsis of Gynecology by Doctors Beacham and Beacham, is widely regarded as a concise and practical summary of clinical gynecology. This book has kept pace with the many advances and increasing complexities of gynecology in the past decade, yet still manages to emphasize fundamentals in the treatment of gynecologic disorders. Many of the current chapters have been rewritten, such as those dealing with chronic dystrophic vulvar lesions, diseases of the breast, septic shock, and the multiple concepts of endometrial bleeding. The chapter on medical-legal aspects of gynecology has been updated to conform to the present feelings in this field. Also, a new chapter on contraception has been added, and provides an overview for the clinician dealing with contraceptive practices.

In summary, this book is of great value to the individual who does not have the time to run through many textbooks, and it will provide answers for the majority of clinical problems encountered in gynecology, as well as an indication when further reading is worthwhile.

L. David Ekvall, M.D.

MODERN TREATMENT. Published by Hoeber Medical Division.

This booklet represents a bi-monthly study of selected medical problems. The November, 1967, issue contains two symposia dealing respectively with obesity and the treatment of burns. The symposium on obesity discusses metabolism, genetic factors, psychiatric factors, dietary treatment, drug therapy, obesity in childhood, and management of cardio-pul-

monary disorders in the obese. The symposium on burns includes evaluation, local treatment, systemic treatment, and psychotherapeutic treatment of the burn patient. Each of these articles includes up to date information on these various topics.

It would appear that a certain amount of repetition is unavoidable in the presentation of views by various authors on a similar topic. The subjects, however, are presented in an up to date and concise manner.

It is hard for me to see why the collection of these articles makes them more available, or more convenient than they would be published separately, to a clinician reviewing recent progress in the field. The accumulated index for the year is presented in this volume and represents a convenient start for research of the literature, but again it is hard to see why this would be an improvement over the Quarterly Accumulative Index.

In some ways this is an interesting volume to browse through, but it hardly is a ready source of comprehensive information on any particular aspect of the problem.

Theodore Shohl, M.D.

CECIL-LOEB TEXTBOOK OF MEDICINE. Beason, P. B., and McDermott, W. (eds.) Ed 12, Philadelphia: W. P. Saunders Co., 1967

The more decrepit of us remember this text simply as Cecil. When Robert Loeb became co-editor, Cecil became Cecil and Loeb and now with Beason and McDermott as editors, it is Cecil-Loeb. No matter. Whatever title, most of us still turn there first in time of need and most medical students are learning medicine from it. So what is it?

An event of this moment will command much attention and many reviews. It has.

Those interested will find Lester King's most informative and satisfying. (1)

The 12th Edition fields a galaxy of 169 stars as contributors. By rough count, these include 47 Full Professors and Chairmen of Departments, 71 plain Full Professors, 6 Deans, 21 Associate Professors, 2 Assistant Professors, and 1 Reader in Medical Protozoology. Two editors and 5 associate editors control the play.

In the present information explosion, the task of organizing, editing and actually publishing before obsolescence, the output of such combined talent, confounds the imagination. And any criticism of the book must start with the question: could it really have been done better under the circumstances?

By good fortune--for the reviewer--the American College of Physicians recently offered its membership an exhaustive (and exhausting) assessment test in Internal Medicine. When it was over, the unanswered questions seemed a good tool to test the mettle of Cecil-Loeb. How did it fare?

In general, pretty well. That is, on most specific questions one can find up-to-date answers reasonably fast. Introductory chapters provide good overall pictures on recent progress and future directions. Bibliographies are mostly short and current. Development in biochemistry, molecular medicine and genetics are reasonably related to the topics at hand. Further, you quickly realize in Cecil-Loeb--contrasted with Cecil--you will never learn it all before the next edition appears and much is changed.

But you will have some complaints.

First, Robert Loeb. His only mention is in the title of the book. Whether by oversight or intent, this omission will sadden those of us lucky enough to have known this man, and should puzzle the contemporary student who may well wonder who he is. Russell Cecil, beyond a short obituary, fares little better.

Next, the index. Why must we be referred to Adams-Stokes Syndrome when we look up Stokes-Adams? Or to Hormone (s), adrenocortical, from Steroids, adrenocortical? Or to Hemorrhage from Subarachnoid hemorrhage. Or, worse, from Tests, glucose tolerance to Glucose tolerance? Just to mention a few of the tiresome and frustrating cross-references. Why not give us the page number, omit the taxonomical education, and be done with it?

Any on-coming internist might inquire about digitalis toxicity. It's not indexed. I wanted the characteristics of synovial fluids in joint disease. It wasn't there. Ulcerative colitis doesn't seem to have a medical treatment. The drugs operative in G-6PDH hemolytic anemia aren't listed or I couldn't find them. Post-gastrectomy anemia is indexed but you're no better off for the reading. There are more.

Worst of all! the Frostbite article omits the definitive reference.

Well, it's a big book. In 1728 pages it covers everything from Abdomen to Zoster and all in all it is a good job. Most of us will use it often and fruitfully.

(1) JAMA 202-151, 1967 (October)

Winthrop Fish, M.D.





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Volume 10, Number 2

June 1968

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Cover photo is a July sunset, taken near Juneau looking toward the Chilkat Mountains 1/100 F8 Ektachrome X by John F. Bowler.

Note: The March, 1968 cover photo of Mt. Dan Beard was taken by Theodore Shohl, M.D.

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# NOREC,

## An Improved Disaster Communications Network for Alaska

By Joseph K. Johnson, M.D.

*KL7FCH, KBL6605*

"This is KL7KC, net control for the Fairbanks Civil Defense simulated emergency test. I have priority traffic for Bassett Army Hospital, St. Joseph's Hospital and all clinics and pharmacies in the area." The time is 1:00 p.m., Saturday, January 27, 1968. It is the voice of "Sandy" Jensen, Emergency Coordinator, Amateur Radio Emergency Corps. Fairbanks Area calling all stations on the two meter disaster net. Mrs. Lois "Sandy" Jensen is at CD headquarters, nerve center for this area in any actual disaster. Emergency communications have been rapidly set up to supplement police and fire department radio. A major disaster is supposed to have just occurred---a vast and destructive earthquake. It is not yet known just how vast and destructive, but there is every indication that a large number of human casualties can be expected. Doctors in the area having two-way radios in their cars are already reporting in on Citizens Band Channel 3. They are receiving instructions and being quickly dispatched to emergency treatment centers. Already, volunteer radio operators have set up portable and mobile radio sets at all hospitals, clinics, pharmacies, Red Cross and Salvation Army headquarters, and other key spots in the Fairbanks Area. All normal communications have ceased to exist and regular electric power is off. At CD headquarters, of course, there is emergency generator power; emergency power is also on at the hospitals and other critical locations in the disaster area. Clinics, pharmacies and hospitals are being contacted by radio to determine the extent of damage and the availability of medical supplies and personnel. Elsewhere in the disaster area powerful ham transmitters are in operation to relay this information, and other vital traffic, to the "outside". And all over the Pacific Northwest amateur operators are standing by to handle disaster traffic directed to specific destinations.

This is a SET---simulated emergency test---conducted under the auspices of AREC, the Amateur Radio Emergency Corps of the American Radio Relay League. Also participating are Citizens Band radio clubs whose members provide on-the-spot, local com-

munications with two-way CB radios in their cars. Working closely with Civil Defense officials, these various organizations of ham and CB radio operators have organized an emergency system called NOREC---Northern Regions Emergency Communications. This organization was put together during the first few months after the great flood of August, 1967. It actually evolved from a nucleus of hastily recruited amateur radio operators, Citizens Band radio operators and other volunteers who served during the flood disaster. On January 27, 1968, NOREC was ready for testing. The date was selected to coincide with the A.R.R.L.'s annual SET involving nation-wide participation by the Amateur Radio Emergency Corps. It was the first time hams had participated in a SET in this part of Alaska and, as anticipated, numerous "bugs" were discovered during our first dry run. But much valuable experience was also gained in the rapid handling of disaster-related communications. The need for regular, carefully planned exercises of this type in close cooperation with our CD officials was borne out, and it is now planned to have another trial run for NOREC this summer. In addition to the annual, nation-wide SET, NOREC will conduct less formal tests two or three times a year.

Any licensed radio operator, ham, CBer or otherwise, may participate, though participation is usually through local radio clubs. NOREC members are issued ID cards and special decals for their cars. In an actual disaster this will facilitate their movement in restricted areas. Also, most hams in Alaska having mobile radio equipment in their cars may obtain a special license plate bearing their own ham call letters. Issuance of these personal license plates was by decree of the Governor of Alaska in recognition of the service performed by hams during the Good Friday Earthquake disaster of 1964.

It is often said that we get emergency situations often enough in Alaska to keep radio operators "on the ball" without the need for formal practice runs. It is true that the really dedicated operator may handle distress calls and priority traffic on a day-to-day basis. But experience in major disasters has shown that team-

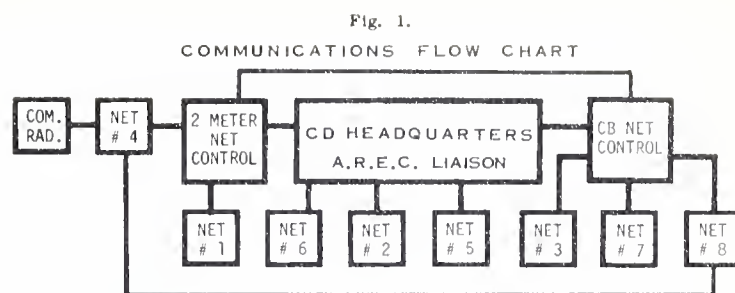


work and organization are far more important than individual operating skills. Despite the tremendous contribution made by volunteers during the great earthquake of 1964, there can be no doubt that a much higher level of effectiveness can be achieved by organization and practice. This fact became even more apparent in the August, 1967 flood. For over 24 hours before flooding began to occur in the Fairbanks area, an emergency radio net was already in operation in anticipation of severe flooding down-river at Nenana and villages along the Tanana. Yet this net was, initially, hopelessly inadequate to cope with our communications needs when rapidly rising water in the downtown area of Fairbanks completely disrupted telephone and wire communication. Of course the emergency net was gradually expanded and eventually involved nearly every ham, CBer, and other licensed operators---and even some non-licensed personnel---in the entire area. However, much valuable time was lost in recruiting and organizing at a time when a smoothly functioning team of operators was most urgently needed.

Under NOREC additional nets will be activated as the need occurs and well-trained groups will be standing by, ready to go into action swiftly and efficiently on command from the CD office.

The communications flow chart at right (Figure 1) illustrates the present organization of the NOREC system. In a disaster these various nets will be activated according to the actual need and would be quickly phased out as regular communications were restored. The various nets operate on different radio frequencies or channels to avoid interference. Liaison with CD headquarters and the central control station would utilize a common channel or frequency, possibly supplemented by field (land line) telephones wherever feasible. The various organizations participating in the relief effort are quite diversified. Depending on the nature of the disaster and the time of year, boating clubs, sno-go clubs, the ski patrol, and other specialized volunteer groups have agreed to participate. The ski patrol, as well as the boating groups, are now equipped with CB radios; trials with sno-go's have proved the practicability of two-way walkie-talkie communication over a range of a mile or two.

The role of the private physician in disaster planning has never been adequately defined. In most parts of the country, at some time, a master plan for utilization of medical, nursing and hospital personnel has been worked out, only to be filed away and forgotten. In comparatively few communities are these plans periodically revised, updated and put into practice in simulated emergencies. One thing that was glaringly



Communications Flow Chart. The basic organization of the NOREC system is depicted. The various nets may not all be needed at any one time but would be standing by, ready to go into action when called. Net 8, for example, would be used primarily to contact military officials in case their own communications link should fail or become overloaded. Military Affiliate Radio Stations (MARS) would probably not be used except possibly to supplement health and welfare traffic to the "outside". As an example of how the net might function in a particular case, let us assume that one of the ham stations in Net 5 has picked up an urgent message from San Francisco to the State Commissioner of Health and Welfare. The station receiving the message calls CD headquarters on a VHF channel and is told the Commissioner is enroute by helicopter to Bassett Army Hospital. CD headquarters may try to hand the message to the chopper via Net 6 or may forward it to Bassett Army Hospital via the 2 meter net control. If sufficiently urgent it might go out on all nets.

CB Net Control -- control and liaison station for Citizens' Radio Service.

2 Meter Net control (VHF ham band control and liaison between CD headquarters and other nets.)

COM. RAD. -- Commercial short wave radio service, control and liaison with commercial subscribers.

A.R.E.C. LIAISON -- Amateur Radio Emergency Corps officer at CD headquarters directs traffic to various nets, principally through 2 meter net control and CB net control stations.

NET #1  
Airport  
Alaska Communications System  
State Building  
University of Alaska, Geophysical Institute  
Civil Air Patrol

NET #2  
Local Broadcast Stations, Radio and TV  
Newspapers and News Services

NET #3  
Salvation Army Headquarters  
Red Cross Headquarters  
Shelters  
Inter-University (University of Alaska)  
Veterinary  
Humane Society  
Health Department

NET #4  
St. Joseph's Hospital  
Bassett Army Hospital  
Doctors and Clinics  
Pharmacists

NET #5  
Interstate and Stateside traffic via high frequency amateur radio

NET #6  
(N.D.T.A.)  
Small boats  
Sno-Go's  
Trucks  
Busses  
Taxis  
Alaska Railway  
Aircraft  
Heavy Equipment

NET #7  
Golden Valley Electric Association  
Municipal Utilities System  
Mayor's Office  
City Council  
B.I.A.

NET #8  
Military Liaison  
M.A.R.S. (possibly)





Fig. 2. The author in action during the flood. Both transceivers shown operated simultaneously at all times and could be switched from regular electric power to emergency battery power as required. Michael, 4 year old son of the author, is preparing a quick snack in the second floor living room radio "shack".

Fig. 3. It was impossible to rescue all of the author's electronic gear from the lower floor. It has now been salvaged as flood waters recede and is being dried in the warm sun. Some of the equipment has been restored to useful operation after replacing water-logged tubes and components.





apparent during the earthquake and flood was the desirability of two-way radio communication with all key medical and para-medical personnel. Thus physicians, caught away from their homes, offices or hospital could call in for instructions and be readily dispatched to the place where they were most needed. During the Fairbanks Flood I was able to respond to calls received on the shortwave transceiver in my pick-up until the water became too deep to get through. Had I become stranded in deep water, I could have radioed for assistance. It is easy to imagine the frustration of physicians caught without any means of effective communication and unable to summon assistance in getting where they might be urgently needed.

NOREC has encouraged physicians in this area to provide themselves with inexpensive CB transceivers having a range of 15 to 25 miles. A typical 5-channel transceiver designed to operate from car battery or portable power pack is available locally for about \$90.00. To this must be added the cost of installation in a car, a suitable antenna, and engine noise suppression if needed---rarely exceeding \$25.00 in extra expense. These small, transistorized units operate at maximum legal power with low battery drain and are quite dependable. NOREC has designated channel 3 as the emergency calling channel for medical traffic. A number of our physicians now have portable or mobile two-way radio equipment, and it is hoped that all will be so equipped in the near future. Also recommended are base radio units to be installed (with provision for emergency power) in the larger clinics and pharmacies. Incidentally, "emergency power" need consist only of a single 12 volt auto battery, though ideally a small gasoline powered generator is desirable. It should be pointed out that an FCC license, available without examination, is required for operation of a CB radio. The application form, which is quite simple, is available from any dealer and should be sent in about six weeks in advance of any contemplated operation. The fee for the five year term of the license is \$8.00, and it is renewable upon application and payment of a similar fee. The license entitles the holder to operate several individual units (transceivers) for both business and personal use. Many physicians find it convenient to have units at home, in the office and in their cars. Any member of the household or office staff may operate the transmitters under the same station license. Physicians having CB transceivers in their cars may obtain a distinctive decal bearing the CD insignia and identifying the vehicle as carrying emergency communications equipment. As has been emphasized in articles in this journal, proper identification of essential medical per-

sonnel by ID card or auto decals will minimize the delay and confusion in getting these people to the right place in time to be effective.

One difficulty frequently encountered in setting up emergency radio equipment in large buildings is securing a workable antenna system. Low power portable equipment can be set up in a hospital corridor, for example, in a matter of minutes. But unless a good outdoor antenna is immediately available, it may be completely unworkable. This happened at Providence Hospital right after the earthquake and was a recurring problem in buildings in the Fairbanks area during the flood. It would be quite simple and inexpensive to erect a good CB and VHF antenna on the roof of every public building. Permanently installed coax transmission lines with standard UHF connectors terminating near the building switchboard or some other central location would eliminate the delay involved in setting up these technical antenna arrangements under disaster conditions.

The U. S. Department of Health, Education and Welfare, region IX participates in an inter-state Public Health Amateur Radio Emergency Net. The West Coast Amateur Radio System acts as a calling service for this net, and specific schedules are set up to handle inter-state health traffic in case of a widespread disaster. As the participating station for Fairbanks at the time of the August, 1967 flood, I was in regular direct radio communication with the regional office in San Francisco. I was also in regular shortwave radio contact with health officials in Juneau and Anchorage during the week of emergency communications. As a matter of fact, the only health service officer I was not in regular contact with was our own Fairbanks Health Officer who had no emergency two-way radio communications constantly available to him.

Every population center in the U. S. A. has a representative or member of this Public Health Emergency or similar amateur radio network ready to maintain shortwave emergency contact with other areas in the U.S. These amateurs are equipped with powerful and highly reliable radio equipment, and have provisions for emergency generator power at all times. In any disaster the Federal Communications Commission may declare a state of emergency on the air. Certain frequencies and bands are designated to the exclusive use of stations handling emergency traffic and special rules are put into effect to expedite the handling of messages from and to the disaster area. Violation of rules or willful interference with emergency radio traffic are dealt with promptly under the law, and both fine and imprisonment may be assessed against any

offender. This official attitude has traditionally maintained the sanctity of the radio frequencies in providing assistance to people in distress. The FCC goes beyond this in a serious emergency---many rules and procedures which might tend to handicap the volunteer operator in his work are suspended. For example, use of FCC licensed equipment by non-licensed operators may be permitted; special frequency assignments outside of the normal amateur bands may be temporarily authorized; and, in the case of the Citizens Radio Service, all 23 channels may be set aside for emergency use with suspension of some of the normal operating protocol.

A brief description of the radio communications services available in an emergency seems in order. The oldest of the non-federal, non-profit services is the Amateur Radio Service. About 60 years old, the Amateur Service closely parallels military and commercial radio services in technological development. Indeed, many of the refinements and basic discoveries in radio communications have come from the hams. Of far more recent origin is the non-technical, non-profit Citizens Radio Service. Of the three classes of license available for this service, Class D is by far the most popular and is the class referred to as "CB". Well over a million active licensees of this class operate on the 23 crystal-controlled channels. CB is primarily intended for short range personal communication. It is well suited also for use by professional people and small businesses. Ham radio, on the other hand, is intended for world-wide, long distance communication as well as many specialized experimental

and technological activities. There are about 250,000 active, licensed hams in the U. S. In addition to providing emergency, long distance communications whenever called on, the ham also does his share in promoting international goodwill. Commercial short wave radio is a third service which may be pressed into action during any serious communications emergency. Taxis, busses, trucks and fleet vehicles of all types are frequently equipped with highly efficient two-way FM radios. Since these units are normally dependent on central base stations for routing and direction, individual units are often restricted to a single frequency or channel. Of course, so long as the base or control station stays on the air, it is possible to tie them into emergency nets. Fortunately, provisions for emergency generator power for the commercial base or control stations have now largely been accomplished by all major commercial short wave systems. In the NOREC plan, close liaison between public officials and the local broadcast radio stations is emphasized. It should be noted in Figure 1 that a special, PR net (#2) provides for this contact. Ideally, all information released for broadcast or publication should be cleared with a regular PR officer acting under authority of the CD office.

In summary, a system of coordinated emergency communications organized in cooperation with Civil Defense officials in the Fairbanks area has been described. It is anticipated that efficiency of communications in any disaster affecting this area can be enhanced by periodic "shake down" tests. It is hoped that the NOREC system can be adapted for disaster communications in other parts of Alaska.

#### ACKNOWLEDGEMENTS

The author acknowledges with thanks the valuable advice and assistance given by Mrs. Lois Jensen, Emergency Coordinator for the Fairbanks area A.R.E.C. Mr. Al Weber, chief of the Alaska Section of the A.R.R.L. offered technical advice and several members of the Fairbanks Medical Association who read the rough draft of this article offered helpful suggestions. Special thanks are in order to the staff of the Fairbanks Medical and Surgical Clinic who assisted in the preparation of the manuscript. Photos are from the collection of Digna Johnson, wife of the author.





# BUSH DENTISTRY 1968 STYLE

By Joseph R. Cumming, D.D.S.

Dental care has been provided to people in the Alaskan "Bush" for many years by many dentists, starting way back in the days when the belt driven handpiece was powered by a little Eskimo or Indian boy on a foot treadle. Although some may not believe it, I was not in dentistry in those days, but the men who were here had a difficult job to do. I shall never forget using the belt driven handpiece that is now in my lab, for doing all the operative dentistry when my wife and I flew an old Cessna around the Bristol Bay area and out along the Aleutian Chain. The use of slow speed to prepare cavities seems almost like a dream now, no one would want to use it again. However, we enjoyed those days, and the years that followed in Nome, with trips to villages in the Arctic. We often used my rather mixed breed dog team to take hunting trips, and usually took along some dental supplies and instruments to take care of an emergency at any village or hunters' cabin we might visit. We had to carry the anesthetic inside our "parkys" to keep it from freezing and we didn't always have the right instrument, but we did the best we could with what we had, and would return later with more complete care.

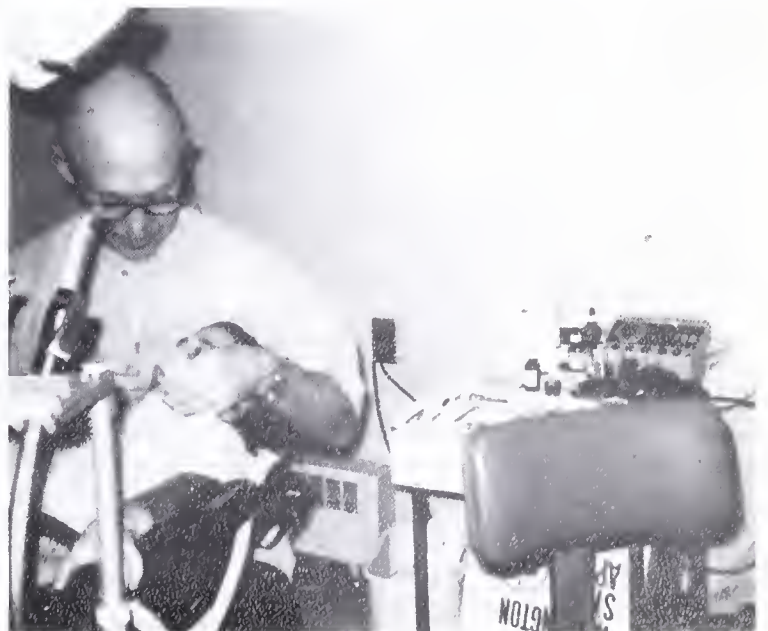
How well we remember arriving at one village with no anesthetic, and with the only instruments available being a screwdriver and pair of water pump pliers. After several minutes in boiling water, they became quite useful in elevating and extracting two very painful teeth from one rather ancient Eskimo. He claimed to be over 100 years old.

There are thousands of truly interesting stories about the real old days but only a very few of the older men are left to tell them. Dentists have traveled by boat to many places in Southeastern Alaska and around the Seward and Bristol Bay areas. Others used dog teams where they could, many used airplanes, and even a few have used automobiles. A great majority of the dentists in this state who have been here any length of time, have done some dentistry in the smaller towns or villages, but eventually the size of the family, the security of a more stable practice, the need for being at home, and the inconvenience of living out of a suitcase brings them back to a city where the economy and population can support a dentist full time.

Along with the advance of civilization in Alaska came advances in dental techniques, dental materials and dental equipment. The dentist's education and practice no longer were confined to "filling holes" in

teeth, "pulling" teeth, and making "plates" as it had been for so many years. His education began to parallel the medical doctor's during the first two years of school; in fact, in several universities the medical and dental students attended their classes together for these basic science years. After that the dentist specialized in the oral cavity, not just in teeth. Now he "restores" teeth to their natural forms, replaces missing teeth, he "extracts" teeth as a last resort, he constructs "prostheses" to provide not only a well functioning masticatory apparatus but also to restore facial contours, and to develop a pleasing appearance in the arrangement of the artificial teeth. He is concerned with the patients total health picture, a part of which includes the teeth, the temporomandibular joint, the gingiva, the tongue, the lips, the bone surrounding the teeth and all the tissue within the oral cavity. He has, or is supposed to have, become a member of the Health Team.

As a result of increased knowledge, providing complete dental care in the "bush" has become a much more difficult and sophisticated process, just as it has become more difficult for the physician to provide more than emergency care to the people in the outlying areas. What the physician used to do with the contents of his "little black bag" he can do no longer, not because he knows less, but because his advanced knowledge cannot be effectively applied in this fashion. Certainly in most instances he is a better trained man than his



Working at McGrath.





Working at McGrath.

predecessor. The same has happened in dentistry. In the days when the dentist's equipment in his office was not much more complex than portable equipment, it was not too difficult to pack it up and move. True, transportation was often not the greatest, but people then were used to hardships while traveling; however, as equipment became more complicated, heavier, and more difficult to move, the itinerant dentist along with the country doctor gradually passed from view.

In recent years however, portable high speed dental equipment has been developed which allows us to do operative work in the field comparable to that in our regular office. We now can have adequate suction to afford a dry field and administer topical fluoride, and we have portable x-ray equipment that can take good diagnostic films. We also have certain dental materials that will allow us to provide temporary

prostheses, if not always permanent ones, to help the patient until he can come in for more thorough care.

In 1967, at the cost of close to \$4,000, the Alaska Dental Society purchased the most modern portable equipment available, and this has been used in several towns and villages throughout the state. A nominal charge of \$10 per day is made to the dentist for its use.

By chance this equipment arrived just in time to be sent to Fairbanks after the flood, when some of the men there had no equipment for their practices for several weeks. Once it was returned to Anchorage, I used it to continue a program with the Federal Aviation Agency that had been started two years before on an experimental basis with borrowed equipment. The FAA at that time had asked the South Central District Dental Society if it had any men who would be interested in traveling to their several sites throughout the state to provide dental care to their people and others in the villages who might be in need, on a private fee basis. As chairman of the Committee on Remote Area Dentistry, I met with the FAA personnel. The first trip arranged was to Kotzebue.

The FAA tries to arrange a trip with one of their aircraft around our schedule, and thus we have transportation to and from the sites, where quarters are usually available. With at least a half day lost in packing and two days lost in traveling to and from the site, the provision of transportation is a large factor in making these trips feasible. On these trips I have traveled to Northway, McGrath, King Salmon, Nome, Tok, Bettles and Medfra. Dr. Bevins has gone to Galena; Dr. Williams to Tanana; Dr. Marley to Northway, King Salmon and McGrath; and Drs. Munns and Hulbert to Cold Bay. We will have men going to



A trip from Nome to Shishmariff.



Type of transportation provided on most trips.



Yakutat, Annette and Unalakleet soon, and other places will be scheduled later. The above is by no means a list of all who have worked in the "bush". It is just the men who have participated in our recently organized effort to provide dental care in the outlying areas, and to share the workload and inconvenience among a greater number of dentists.

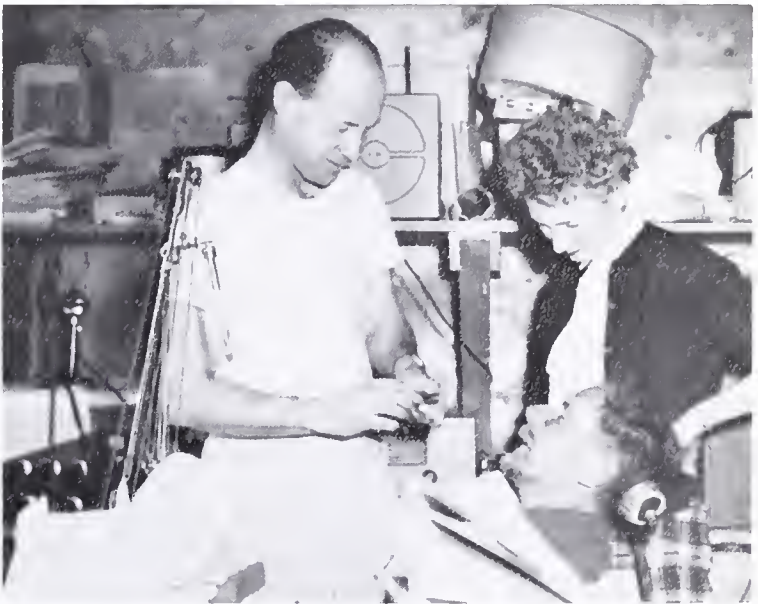
A full time itinerant dentist is a rarity. The closest we have to one in private practice, as far as I know, is Dr. Bob Carpenter who lives at Stony River. He is doing a very fine job along the Lower Yukon and Kuskokwim rivers, but even he has a location in Bethel where he spends more time than at any other one place. All conditions must be right for a man and family to operate under these circumstances and Bob is one of a very few who has everything working in his favor. I admire him and possibly even envy him a little. With Dr. Carpenter, a few others, and our Dental Society program, we can provide a greater quantity of restorative dentistry now, utilizing high speed equipment and well trained auxiliary personnel. We can provide better quality care because of the advancement in techniques and materials, and we can recognize pathological developments earlier because of more thorough training in the general health field; but we will find that we probably cannot provide as great a variety of services as we would wish, because the best materials used today in the field of prosthetics, crown, and bridge, require very specialized equipment for their processing that could not possibly be carried in the bush. Some of this might be accomplished by an early scheduled return trip, but in most cases the people have to come

to the city for the final phase of work.

At present the FAA is setting up a few old surplus dental chairs and lights at the larger sites. This will be a big improvement over the portable chair and headlight. The Dental Society's main equipment consists of a portable x-ray unit, compressor, dental unit and autoclave. Along with this an efficient dental assistant can pack the other necessary supplies for the dentist and hygienist into about eight cartons. We have found cardboard apple boxes are about the best for strength and weight. From their contents she must create essentially two operating areas, an x-ray room, dark room and business office. Where this miraculous transformation may have to unfold we never know. It may be in a kitchen and dining room, a living room, a laundry room or a coffee room in the Flight Service Station. Once we have set up, the order of procedure is to examine all people that desire care, take necessary x-rays, diagnose the cases, present them with an estimate of the required work and arrange a schedule. Usually the days are long, 12 to 15 hours or more, and it seems that the work never ends, but gradually on the return trips we begin to realize that at least the gross problems we first encountered are dwindling, and the work becomes more routine. We will eventually catch up with the neglect, and the day may come when we can combine a little fishing or hunting with the dentistry without feeling that someone is being overlooked or neglected; but regardless of workload the results have been most satisfying, and it is a pleasure to have people so sincerely grateful for the care being extended.



Closeup of new portable high speed equipment purchased by Alaska Dental Society for use in outlying areas. It has high and low speed and miniature high speed hand pieces, suction, air and water syringe, and small cuspidor with water stream to clear it. Compressor comes in suitcase type case same size as this unit.



13 years ago with the old belt driven LHB engine. An unexpected stop over in the only room available.

# Alaska Dental Society Annual Meeting

Following is a schedule of events on the program for our nineteenth annual meeting to be held here in Anchorage from Sunday, June 2 to Wednesday, June 5 at the Anchorage Westward Hotel:

## SUNDAY, JUNE 2

1:00- 3:00 p.m. Registration - Lobby of Anchorage Westward Hotel  
3:00 Bus leaves for Mt. Alyeska  
Fun and Entertainment

## MONDAY, JUNE 3

8:00- 9:30 a.m. Breakfast, Convocation  
Mayor's Welcome  
8:00-10:00 Registration  
9:00- 9:15 Introduction by Dr. John M. Deines  
*Trustee, Eleventh District of American Dental Association*  
9:15-10:00 Dr. F. Darl Ostrander  
*President of American Dental Association*  
10:00- 1:00 Dr. Ralph Phillips  
*"Dental Materials in Practice"*  
1:15- 2:00 Lunch  
2:00- 3:00 Table Clinics and Exhibits  
3:15- 5:15 Dr. Ralph Phillips  
*"Dental Materials in Practice"*  
7:00- 8:00 Cocktails - Ballroom  
8:00- 1:00 President's Dinner Dance - Ballroom

## TUESDAY, JUNE 4

7:45- 8:45 a.m. Business Meeting and Breakfast  
9:00-11:00 Dr. Paul Dawson  
*"Modern Operative Dentistry"*  
11:15- 1:15 Dr. Ralph Phillips  
*"Dental Materials in Practice"*  
1:30- 2:00 Lunch  
2:00- 3:00 Table Clinics and Exhibits  
3:15- 5:15 Dr. Paul Dawson  
*"Modern Operative Dentistry"*  
7:30 Committee Meetings

## WEDNESDAY, JUNE 5

8:00- 9:30 a.m. Breakfast and Committee Reports  
9:45-12:45 Dr. Paul Dawson  
*"Modern Operative Dentistry"*  
1:00- 1:45 Lunch  
2:00 Final Business Session

MEETING ADJOURNED



Dr. Paul Dawson



Dr. F. Darl Ostrander



Dr. Ralph Phillips





Skin lesion of Orf, photographed 21 days after patient had scratched the hand in stalking, dressing and skinning Alaskan mountain goats.



# **A CASE OF ORF**

## **(Ecthyma Contagiosum; Contagious Pustular Dermatitis)**

### **CONTRACTED BY A HUMAN FROM**

### **A WILD ALASKAN MOUNTAIN GOAT**

**By Ralph W. Carr, M.D., F.I.C.S.**

#### Introduction

A new case of this viral disease has been seen, is believed to be the first reported from Alaska, and, as far as this author has read, is the first case reported as contracted by a human from a wild animal.

#### Description

Ecthyma contagiosum, orf, or contagious pustular dermatitis, is a world-wide viral infection of sheep and goats, that is occasionally secondarily transmitted to the skin of man.<sup>12</sup>

The word 'orf' is of great antiquity, and thought to

be derived from the Old English or Saxon word *hreoof*: rough, scabby.<sup>8</sup>

The oral mucosa of sheep and lambs is most commonly affected, though spread may occur to other mucosal surfaces and the skin. Goats also develop the disease.<sup>1-6</sup> In man orf is considered rare.<sup>9</sup> Usually the infected person has not been exposed previously to infected animals or their carcasses, and has been working with them only two to three weeks. It is thought that for human skin to be infected it is necessary for a scratch or abrasion to be present.<sup>4</sup>

Human infections were described by Hansen in a Norwegian veterinary publication in 1879, but not until 1937 were they reported in Great Britain.<sup>9</sup> The dis-

ease is enzootic in sheep in the south of Scotland.<sup>3-4</sup>

Sometimes secondary infection produces ulceration, and this may be fatal, though the mortality rarely exceeds 1%.<sup>10</sup>

Orf is apparently not very contagious, if it is contagious at all, from one human to another. Singular is Lang's report of the iatrogenic transfer of the disease from one patient to another by using the same scissors for opening a pustule in a case of orf, sterilizing them inadequately in alcohol, then using them to remove sutures from the face of another patient.<sup>5</sup>

The virus is cylindrical with convex ends, and measures approximately 260x100 millimicrons.<sup>7-9-12</sup> The virus isolated from the lesion in humans has been found to be morphologically and immunologically identical with the virus that causes contagious pustular dermatitis in sheep.<sup>3</sup> However, diagnosis has usually been based on the clinical picture and history of contact with sheep or goats, because of the lack of a readily available laboratory test.<sup>9</sup>

The incubation period is 3-7 days.<sup>4</sup> The lesion of orf begins as a papule or vesicle, which becomes encrusted and may be umbilicated. The central part of the affected skin has a vesicular appearance, and the periphery is slightly reddened. It may go on to form granuloma pyogenicum.<sup>6-11</sup> The regional lymph nodes may be enlarged.<sup>6</sup> Little discomfort is produced in the absence of secondary infection. General symptoms are mild or absent. The lesions usually clear spontaneously in two to four weeks, according to some authors, and in four to eight weeks according to others. Clearing of the lesions, single, or, less frequently, multiple, occurs with or without treatment. Antibiotics have no effect.<sup>3-4</sup> Little scarring results. Immunity in man is lasting following an attack.

Orf should be considered in the differential diagnosis of rapidly growing tumors and nodules of the skin which have a denuded, weeping surface, violaceous color, or white ring involving the outer three-fourths of the tumor, the violaceous color later becoming red. The above appearance combined with a history of direct contact with sheep and/or goats helps to clinch the diagnosis.

Once diagnosed the lesion is best left alone.<sup>4</sup> Treatment is symptomatic.<sup>12</sup>

### Case Report

On September 30, 1966, a 47 year old, 195 pound local airplane pilot was hunting for mountain goats above timber line near Nooyah Lake (formerly Katie Lake) in the Rudyerd Bay area of the mainland about

40 miles by air from Ketchikan. In stalking the goats through the timber and brush, he received two scratches on his right hand. He shot two nannies which he dressed and skinned.

Both animals showed abnormalities. One, a full-grown goat possibly six years old, had no horns, but only black "bumps" about 4 cm. long. The caps of black material over each bump rubbed off as he dragged the goat, and the underlying horn looked "mealy" and not firm. Hair was thin on the animal, especially on its back, and he could see pink hide through the hair anywhere. As he skinned out the animal, body cavity fluid splashed into his eye and "stung and burned" to such an extent that he was compelled to wash it out with creek water.

The smaller female goat, possibly two years old, had little bumps for horns.

These were about 3 cm. long, but seemed normally formed. However, these also had caps, one of which came off as he dragged the animal, and revealed "mealy" - not solid - horn underneath. The hair of this goat was thin rather than heavy. Also the hoofs were deformed, one with an indentation, and the pads between the hoofs looked as though they had been "shaved off with a razor blade. It looked as though a layer had been sliced right off". Under the anus were two cone-shaped protrusions "like boils not come to a head, but unlike boils they were white, not red, and were hard and firm". There was another similar protrusion above the anus, and a fourth protruding from the skin underneath the proximal portion of the animal's tail. Neither goat was a fat or heavy one. The meat of each seemed normal.

About 7-10 days later - possibly October 8th - the pilot noticed a sudden swelling "like a bug bite" in the middle of the scratch on the dorsum of the web between the metacarpals of the right thumb and index finger. "This puffed up and itched very much like a mosquito bite." His applications of white iodine, infra red heat, aureomycin ointment, and a phenolic ointment "didn't phase it", and it became progressively larger.

This writer saw the skin lesion momentarily as he touched at Annette Island air field October 19th. The lesion was then about 3 mm. in diameter. The application of 0.1% gentamicin sulfate ointment was suggested. That night the pilot noticed tender nodes in his right axilla. The following noon, October 20, 1966, he had transient pains deep in under the angle of the left scapula. When he came to this writer's office October 20th, his temperature was 99.2° F. A culture from the hand lesion showed no growth. He was started on out-patient treatment of twice daily



injections of sodium cephalothin 0.5 gram. On October 21st, he noticed headache, and itching of the lesion on the hand. The lesion had now increased in size, and appeared to consist of an elevated purplish-red nodular ring about a central dry "granulating" area. The right axillary lymph nodes were now less tender.

He was admitted to the hospital October 22nd, and the lesion of the hand photographed (q.v.). As it was suspected to be the "malignant pustule" of Anthrax, he was given injections of sodium cephalothin and kanamycin sulfate. However, another culture from the lesion reported only *Psuedomonas aeruginosa*. White blood cell counts were somewhat low, being 5,500 on October 21st, 4,400 on October 24th, and 6,400 on October 25th. Erythrocyte sedimentation rates were 20 mm/h on October 24th, and 17 mm/h on October 25th. On October 24th, the lesion on the hand was about the size of a twenty-five cent piece, quite firm, red at the periphery, with a dark dry center, and an intermediate white zone. The lesion was biopsied October 27th in an endeavor to determine whether the tissue reaction could be found typical of either the "malignant pustule" of Anthrax, or the cutaneous lesion of *Psuedomonas*.

Pathologist's Report

"Microscopic: The epithelium is thick here and hyperplastic but not in the form of a definite papilloma. It is benign. There is very little inflammatory change. There is a collection of vessels under the surface in one spot, and it may well be that this was protruding above the level of surrounding tissue, so that this may have been polypoid. I don't think it represents a true hemangioma but merely a localized region of telangiectasis of uncertain cause."

"With special bacterial stains, no organisms are demonstrated. I have had no experience with the histology of anthrax, but it does not particularly suggest the details ordinarily recorded. I don't think it could be due to *Psuedomonas*. The histology suggests the possibility of some viral infection, although it is not characteristic of herpes itself. I don't know whether

any viral infection might be associated with the exposure indicated in the clinical information submitted. Diagnosis: Acute vesicular dermal lesion of the hand of uncertain cause."

The writer of this paper notes that the pathologist thought that the histology suggested a viral infection. The *Psuedomonas* previously cultured may merely have been a contaminant.

The patient was discharged from the hospital October 29th, and the hand healed to show only the small biopsy scar.

Follow-up Suggesting Orf

This writer was still mindful of Anthrax, since, as Quarantine Officer of the Port of Ketchikan, he routinely inquires on ships from the Orient regarding possible importation of unsterilized shaving brushes. After Drs. Lillious Taylor and R. Workman Carslaw of the Department of Dermatology, of the Victoria Infirmary, Glasgow, Scotland, published (Lancet, June 3, 1967) their paper on "Cutaneous Anthrax", this writer sent them the above case history, and a Kodachrome slide of the skin lesion. Doctor Carslaw's reply, dated August 18, 1967, was in part as follows:

"The appearance of the lesion on the hand, as shown by the photograph, does not, I feel, suggest cutaneous anthrax. I would have anticipated very much more local oedema, and the colour of the lesion about the periphery would be of a more dark purple hue. From the history of the case it appears that he had a moderate pyrexia developing about three weeks after the original scratch. I would have anticipated earlier pyrexia, and a more acute course altogether."

"May I take the liberty of suggesting another diagnosis, namely Orf - a viral infection. This is known to be contracted from goats as well as sheep. The appearance of the photograph taken on the 21st day is consistent, I believe, with this diagnosis, and the pathology would appear to support this."

"Orf is relatively common in Scotland among people handling hill sheep. I do not know if it is found in Alaska."

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# SELECTIVE RENAL ARTERIOGRAPHY

By James W. Coin, M.D.

Recent progress in the precise diagnosis of disorders of the urinary tract has been little short of phenomenal. The most precise of these diagnostic procedures is undoubtedly selective renal arteriography. Selective renal arteriography is the roentgen demonstration of the arterial tree of the kidney, including vessels as small as the interlobular arteries. The diffuse opacification of the renal parenchyma during filling of arterioles and capillaries, known as the nephrogram, is also included in the definition. The selective arteriogram avoids confusion of renal arteries with superimposed non-renal vessels as can occur during abdominal aortography. The history of arteriography and of selective renal arteriography has been well treated elsewhere<sup>3</sup> and will not be repeated here. It should be noted that Billy P. Sammons, M.D. introduced this procedure in Alaska in 1961.

This publication will review the current status of selective renal arteriography and refer to the personal series of the author, now somewhat in excess of 200 percutaneous arteriograms. Approximately 100 of the studies in this series were performed at the Columbus Hospital in Great Falls, Montana. To date, two patients with primary malignant renal tumors, one with advanced hydronephrosis, two with suspected renovascular hypertension and one with renal trauma have been studied by the author at the Anchorage Community Hospital.

**Equipment:** The equipment currently used for the studies includes a 500 ma. radiographic generator with image intensification and television fluoroscope image presentation. Spot filming if needed for preliminary catheter positioning is by a 35 mm spot film camera which films at two exposures per second on fine grained film with high image resolution. Definitive filming after catheter positioning is by a large film rapid cassette changer which films at the rate of two films per second for a total of 12 films.

**Technique:** The radiologist positions an opaque polyethylene catheter in the abdominal aorta via the common femoral artery by the percutaneous method of Seldinger.<sup>1</sup> This consists of needle puncture and cannulation of the femoral artery, insertion of a guide wire through the needle, removal of the needle and insertion of the preformed catheter over the guide wire. The wire is then removed, and the catheter tip positioned in the appropriate renal artery by fluoroscope and test injection.

**Complications:** No serious complications have occurred in this series. Morbidity was limited to an occasional moderate hematoma at the puncture site. Reported complications include death from anaphylactic shock (rare), occlusion of the femoral artery (most frequent serious complication), embolism of the femoro-popliteal system (infrequent), and laceration of the femoral artery with hemorrhage requiring surgical repair. Film study is aided by an arbitrary division of the films into: early arterial phase (main renal artery only seen); mid-arterial phase (Figure 1); late arterial phase (intrarenal arteries best seen) and the nephrogram phase (no arteries seen but parenchyma uniformly opacified, Figure 2). The veins are not routinely visualized.

**Renal Cyst vs Tumor:** In a recent review,<sup>5</sup> Evans concludes that exploratory surgery to differentiate renal cyst from tumor is now an obsolete procedure, since the accuracy of selective renal arteriography in differentiating the two now approaches 100 per cent.

All authors, however, do not share this favorable opinion, probably due to past indifferent results from single film translumbar aortography. Primary malignant tumors of the kidney have a distinctive abnormal vascular pattern which can be detected when the tumor is quite small. Recent work with direct magnification arteriography has provided resolution of vessels of the order of 100 microns in diameter.<sup>4</sup> Renal arteriography in addition to providing an accurate diagnosis of malignancy precisely defines the extent of the tumor locally. Renal cyst in sharp contrast has an avascular appearance with smooth, rounded, sharply defined margins. The rare tumor within a cyst will most often have abnormal vessels; in addition, percutaneous cyst puncture and contrast study may be done to exclude this possibility.<sup>10</sup>

**Renovascular Hypertension:** Since Goldblatt's classic study in 1934 showing a relationship between renal ischemia and hypertension, intensive study of the blood flow of the kidney has been carried out by many investigators. The incidence of correctable renovascular hypertension is not known with any degree of accuracy. Estimates in the literature vary widely. After a hypertensive patient has been evaluated by various screening procedures, renal arteriography remains as the essential procedure for demonstration of the anatomical arterial stenosis and differentiation of the various types of renal artery stenosis. It is



considered beyond the scope of this paper to discuss renovascular hypertension from the standpoint of history, physical examination, intravenous urograms, isotope renograms, renal photoscanning and the various biochemical studies. Once demonstrated, the hemodynamic significance of the stenosis is difficult to evaluate arteriographically. Pressure studies are of little value. More evidence than simple narrowing of the renal artery is needed before the hypertension can be definitely related to the stenosis.<sup>4</sup> Baum discusses the factors which must be considered: the degree of stenosis, the presence of post stenotic dilatation, delayed "washout" distal to the stenotic segment and the development of collateral circulation.

**Atherosclerosis:** Atherosclerosis is the most common lesion of the renal arteries producing stenosis. The stenosis may be in any location but is most often near the origin of the artery from the aorta and involves only a short segment of artery. Because of its general nature, the process frequently involves the aorta, the coronary circulation and the peripheral arteries. Differential diagnosis is generally not difficult on the arteriogram because of this generalized involvement. The younger individual with recent onset of hypertension may have atherosclerotic narrowing with surgically reversible disease.

**Fibromuscular Hyperplasia:** Fibromuscular hyperplasia is a relatively recently described group of fibrosing lesions of the renal arteries which may be responsible for renal hypertension. It occurs more often in women, is often bilateral and tends to involve the mid or more distal renal artery. It is subdivided by some according to site of origin within the arterial wall (medial, intimal, adventitial). The artery appears beaded on the arteriogram. Complications include microaneurysm formation, subintimal thrombosis and occasionally occlusion of the renal artery with infarction of the kidney. A few patients with hypertension and fibromuscular hyperplasia appear to have responded to corrective surgery.<sup>12</sup> This process may involve other arteries. A recent patient who had a selective hepatic arteriogram because of apparent solitary metastasis to the liver from a prior renal carcinoma was noted incidentally to have fibromuscular hyperplasia of the hepatic artery (Anchorage Community Hospital).

**Aldosteronism:** Aldosteronism is usually attributable to an adrenal tumor, however, occasionally renal artery stenosis is the apparent cause of the syndrome.<sup>12</sup>

**Aneurysms, arteriovenous fistulae and other vascular malformations:** Renal artery aneurysms<sup>4</sup>

calcify in perhaps one-third to one-half of cases and therefore may be suspected from plain film study. Most are asymptomatic but unfortunately have the same complications as aneurysms in other locations including rupture, erosion of surrounding structures, subintimal dissection and thrombosis. Some rupture into a renal vein and become arteriovenous fistulae. Arteriovenous fistulae are much more common than was supposed prior to widespread use of renal arteriography.<sup>7</sup> Two are present in this small series. Fistulae may result from percutaneous renal puncture, trauma, surgery or congenital malformation. A bruit and hypertension may not be present but are helpful for diagnosis when present. (Recently Military surgeons have been reporting an increased incidence of arteriovenous fistulae from missile injuries.) Fibromuscular hyperplasia is prone to result in aneurysm formation. Most renal artery aneurysms are thought to result from atherosclerosis. All of these disorders require arteriography for diagnosis and evaluation. Most are better demonstrated by selective study.<sup>3</sup>

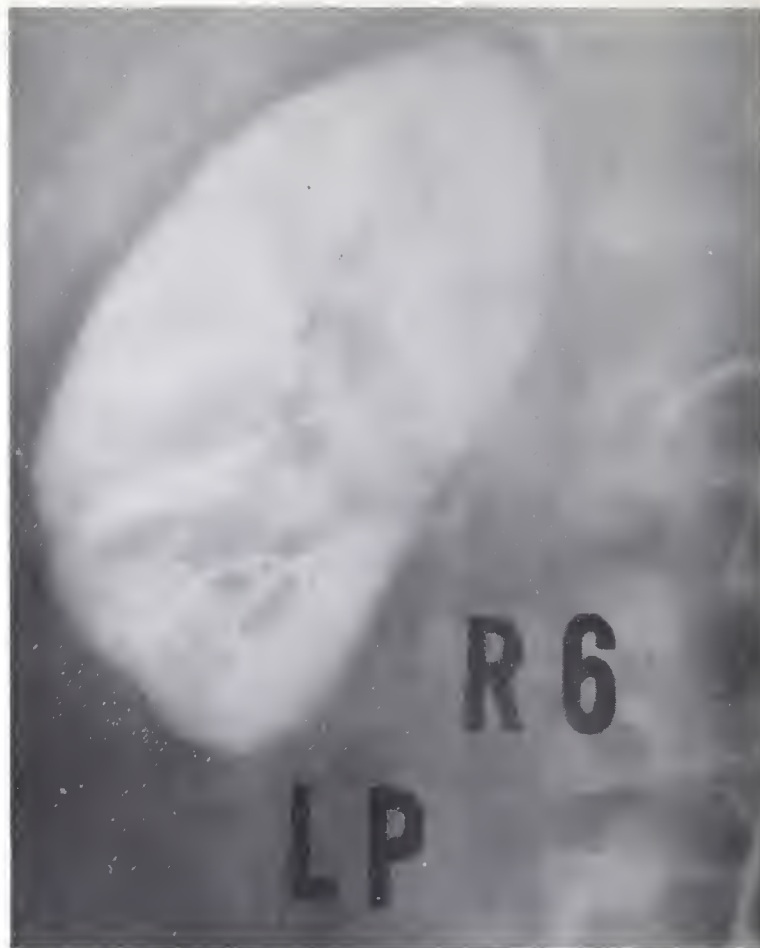
Chronic pyelonephritis may be, and arteriolar nephrosclerosis is most often, accompanied by hypertension. Differentiation of these two entities is difficult and often not possible by renal arteriography. Study of the extent of renal damage by arteriography is quite helpful.<sup>8</sup> It is important to study the parenchymal vascular tree of the kidney in these disorders if surgery is being considered for apparent hypertension secondary to renal artery stenosis.

Both acute and chronic effects of trauma to the kidney can be most accurately evaluated by renal arteriography.<sup>2</sup> Selective renal arteriography in a recent patient at this hospital excluded fracture of the kidney and permitted conservative management rather than surgery. The patient had contusion rather than fracture to account for the hematuria. In accidents resulting from motor vehicles, the kidney is frequently injured. Accurate and rapid identification of the extent of injury is essential for proper care of the patient. Fracture of the kidney can be clearly shown and differentiated from contusion. Trauma may result in hematoma with partial or complete occlusion of the renal artery and infarction of part or all of the kidney.

Selective renal arteriography has been applied to a variety of conditions. For example, arteriography is done in evaluating donor kidneys prior to renal transplantation and in assessing the causes of rejection of the transplanted kidney. The renal arteries are often involved in a variety of general arterial disorders such as Takayasu's disease, luetic arteritis, polyarteritis nodosa and thromboangiitis obliterans.<sup>4</sup>



1. Normal, arterial phase



2. Normal nephrogram phase



3. Malignant tumor, arterial phase



4. Malignant tumor, nephrogram phase





5. Benign cyst, arterial phase



6. Benign cyst, nephrogram phase



7. Arteriovenous fistulae

Selective arteriograms of the lumbar arteries adjacent to the site of prior resection of a kidney for carcinoma may show the suspected recurrence by the typical malignant vascular pattern. The hepatic artery may be selectively catheterized with demonstration of metastases from a malignant renal (or other) tumor by identification of the typical tumor vascular pattern.

The selective renal arteriogram results in intense opacification of the renal parenchyma after the contrast material leaves the arterioles. This phase is called the nephrogram. The nephrogram is helpful in evaluating the amount of functioning renal parenchyma grossly remaining. Therefore, the renal arteriogram is of considerable help in evaluating hydronephrotic kidneys for surgery; in evaluating congenital anomalies of the kidney such as horseshoe kidney; and in identifying infarcted areas of the kidney.

Most arteriographers are now convinced that selective arteriography is superior to nephrotomography and the obsolescent perirenal air insufflation procedures in evaluating adrenal tumors.

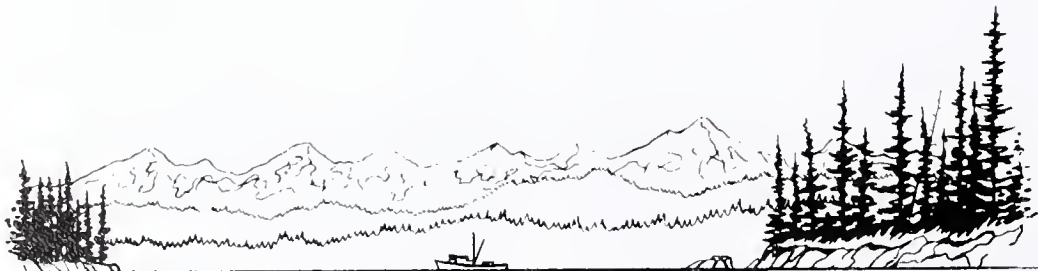
Disorders demonstrated in the present series: Nine malignant tumors were demonstrated by selective renal arteriography, seven in Great Falls, Montana and two at Anchorage. Of these two were 3 cm or smaller in size. Two arteriovenous fistulae were demonstrated as well as several atherosclerotic renal stenoses and two cases of renal artery fibromuscular hyperplasia. One horseshoe kidney was studied, and two unilateral

small kidneys, apparently congenital, were evaluated. Numerous patients showed varying degrees of arteriolar nephrosclerosis. Seven patients had benign cysts, one a 65 male had multiple bilateral cysts without polycystic disease. Many bizarre anatomic variant kidneys were shown not to have tumor. The unusual anatomy with apparent displacement of calyces or distortion of the renal mass, often accompanied by hematuria, were the indications for study. Several patients had multiple renal arteries requiring individual catheter study of three and in one instance four arteries. One patient clinically suspected of having a large renal tumor was found to have primary lymphosarcoma of the spleen with displacement of the left kidney to the right of the midline.

Summary and conclusions: Selective renal arteriography is a diagnostic procedure of great precision with wide application in a variety of kidney disorders. It is not difficult technically, is rapidly performed, and has a very low complication rate. Discomfort to the patient is slight. It is the best method available for differentiating cyst from malignant renal tumor. In the study of patients with renovascular hypertension, it is indispensable. Much wider application of the procedure in the near future is certain. The study of a patient with acute trauma and hematuria should include selective renal arteriography in many patients. Patients with "medical diseases" of the kidney should often have the benefit of arteriography.

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# RECURRING URINARY TRACT INFECTIONS IN INFANTS AND CHILDREN

## A Somewhat Distilled Approach

By John Tower, M.D.

My pediatric training did not particularly endow me with any romantic attachment to the child afflicted with recurring urinary tract infections, I suspect because the usual urinary tract problem seen on the teaching hospital floor was the child with severe chronic urinary tract disease as a complication of horrendous congenital anomalies; vis-a-vis, epispadias, bilateral hydronephrosis with hydroureter. It took several years' experience in private practice before the pleasures to be had in adroitly discovering occult kidney or bladder infection in small children and infants, and bringing these to the appropriate diagnostic study and successful treatment, began to be appreciated. Mulling over the recollections of some 13 years of private pediatric practice bring me to the conclusion that the pleasures to be had in this particular field of endeavor are very much akin to those enjoyed by the capable fisherman who anticipates the eager grayling or lively rainbow concealed beneath every placid and harmless pool along the stream.

The hallmark of good work in this field certainly is undue suspicion. My practice was established before I was fully cognizant of how much undetected urinary tract infection lurked inside the children brought in for routine well-infant and well-child checkups. I owe, I think, a particular debt to Dr. Helen Whaley for this conviction. During the period of time in practice when we customarily did our own urinalyses from the start to finish in a rather poor and crowded laboratory set-up, she made a routine of the collection of a clean voided urine specimen from every child; particularly from every girl child presenting for routine well-child checkup, and she also instructed her nurse to cleanse the genitalia and bag infants, so that a urine could be secured during the course of a routine checkup.

Some years past, the discovery of an unanticipated urinary tract infection by the laboratory technician was refined still further by a deliberate historical search for this information. Now I find it routine during the course of a well-child checkup, a pre-kindergarten or a pre-school checkup, or an infant one-year-old checkup, to make some inquiry about the force of the urinary stream; whether the mother can hear a vigorous gush

of urine when the child voids in the potty, or whether the mother or father has seen a boy urinate forcibly at the toilet bowl. In addition, the past history has proved helpful, at least to the extent that I can ascertain if the child has had a past urinary tract infection or pyelonephritis, and how adequately this was treated; whether an intravenous pyelogram was done and whether or not the child has enuresis.

Physical findings that have impressed and interested me over the course of years have been, first and foremost, the palpation of an enlarged or obvious bladder above the pubic symphysis. Next, the discovery of any hectic or high fever of undetermined origin, particularly in a girl without obvious physical cause for it, demands in my mind a careful, and often a repeated search for pyuria or bacteruria. Thirdly, both in the ill child and the one presenting for routine well-child care, I make it a practice to glim the urinary meatus. Often enough to be interesting, there have been evidences of a meatal stenosis which does appear to significantly obstruct the free flow of urine in boys. Again, often enough to be interesting, in girls under six, one is first apprised, as is the mother, by the finding of almost complete labial synechiae. This conglutination of the labia minora often leaves only a pin-point orifice for the escape of urine from the vulva, usually near the clitoris. Although pediatricians and gynecologists are somewhat divided in their strong feelings about the necessity of treating this condition, I have found on enough occasions that, where the labia minora were nearly completely sealed, there was an accompanying pyelonephritis or pyuria.

In the very small infant, any sort of abnormal flank masses certainly call for immediate and thorough urological investigation. About once a year we founder on some poor infant who has a palpable abdominal mass, thin urine, whose IVP fails to visualize any recognizable structures, and who in no time flat is in uremic failure secondary to severe obstructive disease of the ureters or urethra. When pyuria, dilute urine, palpable abdominal masses, elevated NPN, and failure of any renal structures to visualize in the IVP make one suspicious of severe congenital renal anom-

alies in the very young infant, I feel it is worth referring the patient to the nearest urologist and encouraging him to explore if necessary, so as to seize every opportunity for relieving an obstruction that may be present. Most physicians have found by personal experience that dysuria and frequency are often the hallmarks of legitimate urinary tract disease, although commonly in the child between two and five they are just a harmless behavior disorder. I have personally not found that CVA tenderness was a commonly recognizable finding in the child with apparent pyelonephritis.

In any girl, the second, or at least the third, episode of recognizable pyelitis or bacteruria encourages me to order an intravenous pyelogram and, if possible, a voiding cystogram. Any first infection in a boy infant or a boy encourages me to do the same. Even when intravenous pyelograms fail to reveal evidence of congenital anomalies of the kidneys or ureters, or to suggest a bladder outlet obstruction, I continue to follow the child's urine every three to six months, preferably by having the mother bring the child to the office where a clean voided mid-stream urine specimen can be secured. If the child has been much afflicted with pyuria, we usually secure an overnight colony count on the clean voided mid-stream specimen. By this time the mothers of the children,

as well as our office personnel, have become quite facile at securing such a specimen. If, despite a normal intravenous pyelogram, the child continues to have evidence of recurring bladder infection, with or without fever, we are usually quick to recommend a urological referral for cystoscopy and possible retrograde studies, as well as a cystogram, in hopes that reflux may be detected.

It has been a distinct impression that, by prompt and thorough treatment, often for a 20 to 30-day period, with the ready use of prolonged periods of sulfa or Furadantin prophylaxis; with the careful indoctrination of mothers to be ultrasuspicious of possible kidney infection when the child is feverish or fussy; and with the child instructed in the technique of double voiding at least once a day; often the child (usually a girl previously afflicted with many episodes of pyelitis or pyelonephritis) appears to outgrow her difficulty in the seven and eight year old age bracket. However, sensitizing the child's parents and her physician to the possibility that he or she may be stigmatized through life by a tendency to urinary tract infection, and possible progressive kidney damage due to pyelonephritis, is the necessary responsibility of the first physician to know that the problem exists.





# THE UROLOGIST AND PEDIATRIC URINARY TRACT INFECTIONS

By Alistair Chalmers, M.D.

Common presenting symptoms include: frequency, urgency, dysuria, enuresis and hematuria. Other members of the family may complain of the patient's offensive urinary odor. The child may have an unexplained high fever or may just appear unwell with malaise and anorexia. Most commonly there are few if any complaints and routine urinalysis reveals pyuria or bacteriuria.

In my interrogation of the patient and the parents I seek answers to such questions as--does the incontinence really constitute a form of marked precipitancy? What is the character of the urinary stream--its breadth, force, and continuity or otherwise? Is the bladder emptied during initial micturation or is it emptied in two stages? What time is spent in the toilet at home--both its frequency and duration? And what is the character of the toilet demands at school, and when playing outside?

Fever may well be accompanied by chilling and rigors or, in the young, hallucinations and convulsions. The family history is seldom helpful but a past history of genito-urinary tract infection should be sought. Personal observation of the urinary stream should be attempted, where practical, as historical data may be fallacious. It is well also at this time to inspect the anterior urethral meatus, and the vulvar region in the female. Abdominal examination should include palpation and percussion as well as inspection, or otherwise a large bladder or renal pelvis may go undetected. Anal sphincter tone may aid in the assessment of the external urinary sphincter.

Further aids in diagnosis include urinalysis for routine culture, colony count and sensitivity, the intravenous pyelogram with satisfactory preparation and including a post-void film, the voiding cystourethrogram and the cysto-urethroscopy. Obstruction is the most common contributing factor in urinary tract infection and the etiology in the young is often congenital. As with Dr. Samuel Johnson's comment regarding a Scotsman, much may be achieved if diagnosed early, and therein lies the value of routine urinalysis when checking the apparently healthy child, including a stained smear for organisms. Methods of urine collection vary with the age and sex. In males of all ages from early infancy, patience will be re-

warded by a cleanly caught "midstream" (second glass) specimen as satisfactory as any obtained by catheter. In females, where cooperation is possible, the vulva is cleansed and the labia held apart while the patient is in the lithotomy position, and voiding is requested into a container held close to the vulva. The mid-portion of the stream is collected. The promise of a lollipop in the younger age groups will often motivate urination. In infants a pediatric urine collection bag may be helpful. However, where necessary, a urethral catheter collection or a suprapubic bladder needle aspiration can be utilized. As described by Smith,<sup>1</sup> the phenol red test can be conveniently utilized as a measure of residual urine.

It is often impossible to find a satisfactory explanation for a urinary tract infection. However, recently, with the aid of new radiological techniques, the concept of "hydroflux" as a disease entity has evolved.<sup>2</sup> This disorder is always due to a damaged uretero-vesical valve. Under normal circumstances the uretero-vesical valve allows the urine from the ureter to enter the bladder, but prevents the urine in the bladder from flowing back into the ureter. This protects the kidney from the pressure changes in the bladder and from contamination with infected bladder urine. When this valve becomes incompetent for any reason, bladder urine regurgitates into the ureter (reflux) and a functional obstruction develops in the lower end of the ureter at the uretero-vesical junction.

The three distinct features of hydroflux are as follows: 1. Partial obstruction of the ureter occurs where it enters the bladder--the resulting ureteral dilatation progresses upward to involve the entire ureter, renal pelvis and calyces. 2. In spite of the apparent obstruction in the ureter, there is no actual occlusion of the lumen. 3. Vesico-ureteral reflux is a common occurrence.

The integrity of the uretero-vesical junction depends on the obliquity of the intra-vesical ureter which is maintained by an intact Waldeyer's sheath (the outer oblique, or spiral, layer of the ureter) in continuity with the middle circular muscle layer of the bladder; and the supporting bladder muscular tissue composed of two distinct structures--the sling fascia, and the sling muscle, from the middle circular,

and the outer longitudinal layers of the bladder respectively.

Primary causes of reflux are; infection, absence of detrusor support for the intra-vesical ureter as in congenital para-ureteral diverticulum or autonomous neurogenic bladder, short or absent intravesical ureteral segment with a completely gaping orifice, or with the intravesical ureter short but present. Reflux can be associated with bladder outlet obstruction either with a normal uretero-vesical junction or with an abnormal uretero-vesical junction, with a ureteral orifice nearer bladder neck than normal (not including the orthoptic ureter in duplicated systems), or it may be iatrogenic due to incision of a ureterocele, or just idiopathic.

**The vagaries of reflux:** It is often not consistently demonstrable; 14 per cent of children with no history of infection will reflux; 25 per cent of children with one episode of urinary tract infection reflux. A bladder with marginal ureteral orifices can reflux, although there is no appreciable residual urine, no infection, and a normal voiding pattern. Many patients with reflux can be treated conservatively with long term anti-bacterial therapy and urethral dilatation for anterior urethral fibrous linear stenosis.

Indications for surgical correction while on this conservative management include evidence of renal damage, deterioration of function, and breakthrough infection. When reflux occurs in the male, renal damage is likely to be secondary to an increase in the hydrostatic pressure in the upper urinary tract. In the female on the other hand, urinary tract infections resulting in pyelonephritis are the principal cause of renal damage and consequent deterioration of function. (The average length of the female urethra is 3-4 cms. and there is a urethral bacterial flora normally present in the distal 2-3 cms. in either sex.) Aids to the assessment of renal damage include the differential P.S.P. (phenolsulfonphthalein) test and renal scanning. The rationale for the initial conservative management of reflux in all but the most severe forms is the maturation of the intra-vesical ureter which occurs up to the age of 10-12 years. (The length of the intravesical ureter in the young child is 5 mms. while in the adult it is 15 mms.)

#### A Representative Case History of Reflux

This four year old female patient was first seen in October, 1966 on pediatric referral because of dysuria, enuresis and pyrexia to 103°.

The past history revealed a urinary tract infection

at age two. She was again seen at age three because of fever of unknown origin and a history was obtained of numerous other episodes of fever of unknown origin. A pediatric investigation revealed the presence of pyuria. Urological investigation at that time revealed a large urinary bladder with high pressure reflux on the left, filling the entire left upper urinary tract to the level of the renal pelvis and calyces. Cystoscopy performed in Bellevue, Washington at that time, revealed extreme bladder neck obstruction, which was treated by transurethral resection. Post-operative urinalyses including culture were negative on several occasions. Suppressive chemo-therapy was maintained until February of 1966.

In September of 1966, the patient presented with frequency, dysuria, enuresis, and a history of recurrent chronic left pyelonephritis with a spiking fever. Urinalysis revealed pyuria, hematuria and proteinuria. Physical examination revealed supra-pubic dullness halfway to the umbilicus, but no costo-vertebral angle tenderness. The liver was palpable 1-2 finger breadths below the right costal margin. Chest examination was unremarkable. Rectal examination was impossible because of the patient's unwillingness. Blood pressure was 100/60.

Comparison of the urological x-rays obtained in 1965, with those obtained in 1966, revealed a decrease in the size of the left kidney with less renal cortical tissue, but no gross change in the calyceal pattern. There was noted to be some progression in the pyelonephritic scarring, and on the 1966 studies both high and low pressure reflux were present. On the voiding part of the cystourethrogram, there was noted to be left caliectasis, hydronephrosis and increasing hydroureter, with kinking and also narrowing of the distal left ureter. The reflux was seen to involve the complete length of the left ureter and the renal pelvis. The bladder was noted to be large, although the bladder neck appeared well funneled. With clinical and laboratory evidence of deterioration in the left renal function and recurrent urinary tract infection, left corrective uretero-vesical surgery was performed on December 15, 1966.

Since surgery, the patient has been virtually asymptomatic, and it is planned to maintain suppressive anti-bacterial therapy for 24 months post-operatively.

Intravenous pyelogram studies obtained in January of 1968 were compared to those obtained in September, 1966. These studies have revealed no deterioration in renal function, although as might be expected, there



is still some left upper pole caliectasis and hydro-ureter. There is no significant post-void residual.

When last seen on February 22, 1968, the urinalysis was unremarkable and there was a history of a good

urinary stream with adequate control and nocturnal enuresis. Although there has been some urinary spotting since the last surgery, she is able to hold her urine well and has been asymptomatic since surgery, apart from some vulvar itch and smarting.

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**VOIDING CYSTOURETHROGRAPHY**

**By Bruce C. Wright, M.D.**

At the Providence Hospital voiding cystourethrograms are done utilizing multiple spot films with standard image intensifier. The bladder is filled in a retrograde fashion via indwelling Foley catheter and spot films made of the filled bladder in AP and both obliques. Reflux is frequently observed at the fluoroscopic screen during filling phase of the bladder and appropriate spot films are made at that time. Upon removal of the Foley catheter, the patient usually voids promptly and six to eight spot films are made

during the course of micturition; with the urethra, base of bladder, and reflux if any demonstrated to good advantage. While cine is of definite aid in voiding studies, it is by no means essential.

All of the figures shown on pages 88 and 89 are lesions that have been found within the past year at the Providence Hospital Radiology Department. This is a small sample of the amount of lower urinary pathology present in a medium sized community if it is avidly sought for.



Fig. 1. Ten year old boy with posterior urethral valve. Few symptoms were present. This was discovered in the course of complete urologic work up after I.V.P. disclosed hydronephrosis. (See Fig. 2)



Fig. 3. Post void KUB after voiding cystourethrogram shows reflux filling of entire right renal collecting system.



Fig. 2. I.V.P. of boy described in Fig. 1. Routine study for assessment of G-U tract after bacteria seen on urinalysis.



Fig. 4. Bilateral reflux and evidence of pyelonephritis in a young woman known to have recurrent "bladder infections" since childhood.





Fig. 5. Bilateral reflux in a boy with bladder neck contracture (lower faint ring is a normal structure).



Fig. 7. End frame of voiding study showing massive bilateral ureteral reflux.



Fig. 6. A "Hutch" diverticulum of the bladder with low pressure reflux. (Note that lower ureter enters diverticulum).



Fig. 8. Left sided ureteral reflux. Bladder shows crenation of its surface with bullous edema from cystitis.

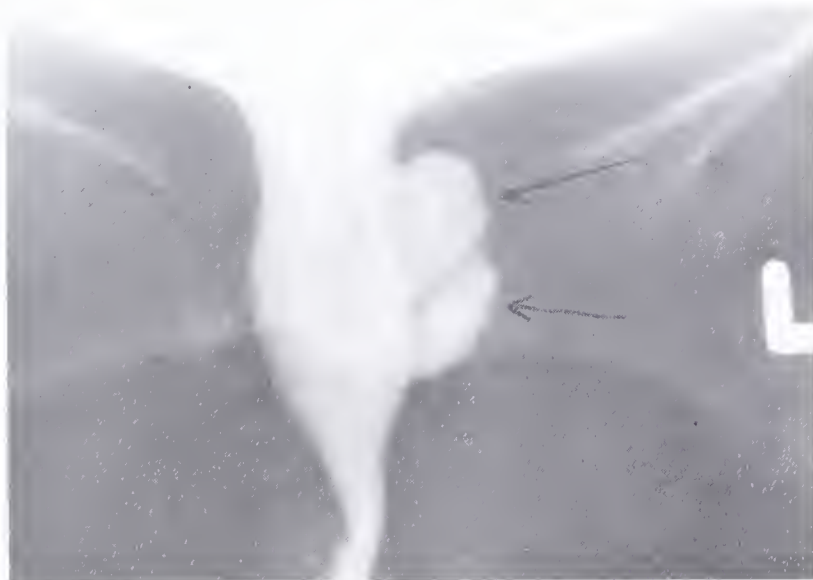


Fig. 9. Multilocular urethral diverticulum in a young woman with recurrent "bladder infections." (Three such diverticula were found in this department in a 6 month period. All three patients had been treated many times for cystitis.)

# FIRST ALASKAN HEART TRANSPLANT REPORTED

By A. von Hippel, M.D.

## Introduction

Alaskans can well be proud that they have entered the surgical "big-time", for in February, 1968, we were finally able to notify the press and T.V. that we were prepared to do our first heart transplant. Subsequent releases carried on the national wire services have resulted in excellent publicity. Generally the reaction across the nation has been favorable although our efforts at preparedness were castigated in one article from New York, and we did get a letter from California suggesting that we restrict our transplant surgery to monkey glands. We feel, however, that we are ready, for with so little known about this procedure, no one can prepare perfectly.

All we lack at the present time is a willing donor, a willing recipient, and some of the technical know-how and equipment. Therefore, in fairness to the citizens of this great land, we plan to provide Alaskans an opportunity to be recorded among the first heart transplant patients at that great follow-up clinic in the sky.

## Material and Methods

O.R. Because of limited facilities and the demands of station KRAB (high bidder for the sole video rights), we have had to sacrifice sterility of the operating suite and remove one wall, to permit zoom shots of the team and the patient. Actually this was not a problem as the wall had not been replaced since the earthquake.

In the absence of proper dog surgery facilities for this complex type of work, and because of a possible conflict with the winter dog racing schedule, we have skipped the usual preliminaries involving 39 mongrel dogs. Our preparation has consisted of several "dry" runs, with the entire team gowned and splashing about in a bucket of moose blood. We now have excellent lighting and camera positions. Auditioning has also been completed. Since many of the medical team do not have the proper dramatic or voice training, it has been found necessary to provide a substitute team of professional actors for the surgeons originally chosen. This substitution is not expected to alter the outcome, so the hospital has agreed... provided that funds are guaranteed to build the new hospital wing. The surgeon's union has also agreed, provided that a standby crew of qualified surgeons will get their usual fees.

On screen testing, the heart-lung machine operator

turned out to be the best commentator, and he will, therefore, be unavailable to run the pump during the actual procedure. This is not entirely a loss as he was a bad actor anyhow. The nurses usually provided by the hospital will play their customary roles although some padding and alterations are contemplated.

The details of the operative procedure, as evolved after several dry runs, have been mimeographed and distributed as part of the hospital disaster plan. To avoid litigation, or any ethical problems, we plan to proceed only after a certified death certificate is available for both heart donor and heart recipient. For maximum publicity we plan to use only well known local donors and recipients. Out-of-state patients need not apply. Any drug or supply firm wishing mention or demonstration of their product during the actual procedure should immediately contact the author, care of Alaska Medicine. There will of course be a charge for this service.

## Actual Case Reports

So far, of course, we have not done one of these operations, but we expect to do several when the T.V. time is available. As we do not have all the facilities available to the larger medical centers, we do not have a team standing by, but we can proceed on short notice whenever station KRAB has their men ready.

## Results

Unfortunately all of our patients will not survive the operation. This should not be criticized, as our results will compare favorably to those of a number of other centers. We would certainly expect to be included in any future nationwide T.V. panels or Senate investigations of heart transplantation and its potentials.

## Discussion

Several original modifications of previously reported techniques and procedures will be used. We believe that they will not adversely affect these heart transplantation procedures, and after a review of our results as well as those of others, several of these innovations appear to be practical.

First, after several discussions with the under-



takers union, which objected to the technical problems caused by the absent heart in the donor and the leaky suture line in the recipient, we have agreed to use embalming fluid as a portion of the pump prime for both of the extracorporeal perfusions. In addition, because of the poor state of preservation, and the clots anticipated in both donor and recipient, we plan to use moose blood for the remainder of the pump prime. We will freeze this moose blood, as the operation may well be done "out-of-season". An exhaustive review of the open-heart literature indicates that frozen moose blood has never before been used for extracorporeal perfusion, but we anticipate no difficulty in this, and can recommend it without reservation for use in certain cases. We are presently in contact with "Boone and Crockett" and hope to get our procedure listed.

### Summary

Alaska's first heart transplant procedure herein reported represents a number of "firsts" in the field of heart surgery.

1. The first heart transplant procedure done entirely by professional actors.

2. The first use of frozen moose blood combined with embalming fluid for extracorporeal perfusion.

3. The first article published about a new open heart procedure before the procedure is performed, in which a five year follow-up of the patient has been given.

4. The fastest heart transplant procedure yet recorded. (We are allowed only 30 minutes by KRAB and plan to use only 4 sutures, some staples and a little "Elmers").

5. The first open heart operation in which candidates for local and statewide office were allowed to participate.



"Waiting for the Whale to Surface", property of the artist, Fred Machetanz, 32 by 52 oil painting on masonite. This painting depicts a group of hunters for whale in an umiak or skin boat off Pt. Hope. A whale has been sighted and they have left their camp along the edge of

the ice field and have gone out after it. As is so often the case, the whale has submerged when they got close to it. Now they are waiting for it to reappear so they can continue the pursuit. The whaling harpoon is seen in the prow of the umiak.

# ALASKAN DOCTORS AND THEIR NEW LIBRARY, AN INTRODUCTION

By Ursula P. Strash

*Librarian*

*Alaska Health Sciences Library*

Rodin's "Thinker" appropriately graces the halls of learning in the magnificent library recently described in the pages of this journal (1). Its extensive services are provided by a professional staff of 26, backed by a collection of some 2,200 journal titles, nearly double that number of monographs, and special subject collections rated among the finest in the world. The services are yours for the asking. The library, of course, is the AMA Archive-Library.

Why then talk about another library? Especially, one that by any comparison is small and not well-to-do, with its books and journals stacked for the most part in heaps on the floor.

This small library, now barely beginning, is the Alaska Health Sciences Library at the Alaska Native Medical Center. Located at the largest of the Anchorage hospitals, it is intended for the use of all physicians and allied health personnel in Alaska.

This library is expected to answer a need felt by

many, a need that cannot be met by a library, be it ever so large and splendid, hundreds of miles away. The physician, foremost among health personnel, must have access to the medical literature, not every now and then, but around the clock, in his day-to-day care of patients. Even then, he is hard pressed to keep pace with the latest developments. Few physicians are able to maintain the extensive private collections needed for this purpose (4).

A good medical library in a community can have a decisive influence on improved patient care (2). To this end hospital libraries represent an economic and efficient investment. Incorporating a library budget into a hospital's operating expenses, however, is another matter, and the initial funds required to begin the operation may all but cause the project to founder.

Recognition of the serious plight of medical libraries across the nation, with the dangers inherent in this, has led to various federal library support pro-





grams in recent years (3). Other programs benefit libraries indirectly. One of these, PL 89-239, or the Heart Disease, Cancer and Stroke Amendments of 1965, has emerged as a most unusual and interesting piece of legislation after some initial controversy over some of its central concepts. In its present form active local community participation and cooperation are required to initiate any project, and federal interference is kept to a minimum. Established principally to bring the latest medical knowledge in the diagnosis and treatment of heart disease, cancer and stroke from the research centers to the general practitioner, the law has obvious implications for libraries, although it is not intended to duplicate the programs of the National Library of Medicine (10).

PL 89-239 is administered by the new Division of Regional Medical Programs in the National Institutes of Health. The states of Washington and Alaska combined into one region under this program (11). In the spring of 1967 the Anchorage medical community applied to the Regional Advisory Committee of the Washington/Alaska Regional Medical Program for assistance with their library.

Help came about one year later. During the intervening months the grant proposal passed through several metamorphoses, of which the most critical was a reduction by 40 per cent of an already pared down version of the original request. The library project now stands to receive \$22,605.00 during the first grant year, and \$10,222.00 during the second. The two grant years cover the period from February 1, 1968 through January 31, 1970. The project title of the library under the Regional Medical Program is the Alaska Medical Library; its actual name is the Alaska Health Sciences Library. Although both terms are being used, there is but one library.

The Alaska Health Sciences Library will have a dual function. It will be the community medical library for the entire Anchorage area. As such it will provide services to all health personnel residing here; further, it will initiate a program of shared professional services with smaller Anchorage medical libraries lacking trained personnel. In its larger role it will provide library services to all physicians, dentists and allied health personnel in Alaska.

Marion H. Johnson, Director of Communications, Washington/Alaska Regional Medical Program, described current WARMP projects in the March issue of *Alaska Medicine* (7). She stated that by the close association of the Alaska Medical Library with the Northwest Regional Medical Library, "Alaskan doctors regardless of their isolation will now have the same

reference services and current literature which is available in the largest medical centers". This is the much discussed concept of "equal access to biomedical literature".

In the practical application of this idea, thorny problems arise. It immediately becomes obvious that "equal access" is all but impossible. Access, yes, but it cannot be equal. No substitute for actual use of a library has yet been found. If it had, a few large regional library centers might be the answer after all.

Instead, every effort is being made to encourage the growth and improvement of the smaller and smallest community or hospital libraries because of their vital role in the nation's health program (10). It is a monumental task, and we owe immense gratitude to the many people across the nation who are turning their time and talents toward a solution of these problems. Some interesting and revolutionary plans are emerging (6, 9). Basic to all is the plan to create a national network of libraries (5). At its core will be the National Library of Medicine assisted by several large regional resource libraries, potentially capable of serving their regions; these, in turn, will be linked directly or through sub-regional libraries to the small community medical libraries. The national library resources would thus be accessible to all library users. Regional medical libraries are presently being established with federal aid. Among their many other obligations, it will be mandatory for these libraries to conduct surveys of all existing library facilities within their region and come up with practical recommendations for their improvement. Further, they are to initiate training courses and programs for the many individuals in charge of these facilities who lack the proper training and preparation.

Consequently, establishing the Alaska Health Sciences Library with state-wide coverage should not cause other library projects in the state to be abandoned; on the contrary, it should see the beginning of much increased activity. Jointly with the Health Sciences Library of the University of Washington, now the Northwest Regional Medical Library, an attempt will be made to help improve Alaskan community medical libraries, as soon as funds become available.

None of this will happen overnight, yet physicians must have library service now. Physicians in the more isolated areas of Alaska always will have to rely on relatively distant libraries for service. To bridge these gaps, and to provide services where they are needed, will be the task of the Alaska Health Sciences Library.

Not knowing precisely what library services are

needed and wanted most by Alaskan physicians and dentists, the schedule of proposed services is tentative and will be adapted as needed.

By the end of June all physicians and dentists will receive a detailed outline of available library services from the Alaska Health Sciences Library. Briefly, these will be:

Borrowing privileges: Books and journal articles may be borrowed from the library. (Xerox copies will be sent instead of the original journal issue or volume). One-day service will be provided for material in the library's collection. Items not in the local collection will be obtained by interlibrary loan. This will introduce an additional time element of from 7 to 21 days.

Literature searches: The library will fill subject requests by searching the literature. Xerox copies of pertinent articles will be sent to the requesting physician or dentist. If the request is urgent, articles sent will be limited to material available in the library, otherwise, additional material may be obtained through interlibrary loan. If an extensive search is requested, the number of articles warrants, and time is not an element, a tentative bibliography will be submitted for selection to the person making the request. In the event a subject is one of recurring or continuing interest, individuals may ask to receive future articles as these come to the staff's attention through journals or indices.

Reference requests: The library will answer whatever requests it can within the limitations of its resources; other requests will be referred to an appropriate resource library, department, agency, etc.

Accession lists: All physicians and dentists who so desire will be placed on the library's mailing list for library acquisitions. Most of the material listed may be borrowed.

Journal holdings list: A list of the library's journal holdings will be mailed to all physicians and dentists some time early next year.

"Table of Contents" service: This service will be made available to physicians and dentists having no direct access to this or other libraries (e.g. the Arctic Health Research Laboratory in College, Alaska). Such individuals may select a number of journal titles which are of special interest to them. A xeroxed table of contents page will be sent to them at the time the library receives the issue. Articles of interest may then be requested from the library.

The Alaska Health Sciences Library is located in the Alaska Native Health Area Office, adjacent to the hospital. The library is accessible 24 hours a day. Its regular eight hours will be extended to include three

evenings of each week beginning in September. More evening hours may be added if required. Emergency service will be available at any time.

Shelves, card catalogs, library chairs and tables and other conspicuously absent equipment will be installed within the next three months. These items are funded out of the RMP grant. Funded from the same source are a library assistant (increasing the library staff 100 per cent!), the partial rental of a xerox machine, and some reference books.

The main burden of support by far falls on the Public Health Service. It is providing space which is at a premium in its crowded quarters; the salary of a librarian; library equipment and supplies; and the library collection, with a heavy investment in subscriptions, binding of journals, back volumes of important journals, and monographs. Currently the library is receiving 150 journal titles, about half of these begin in 1968. Additional titles will be added next year. (Suggestions for journals will be considered). The book collection is still, for the most part, outdated and is slowly being rejuvenated and expanded.

Much credit belongs to many individuals both in the Public Health Service and in the private sector of the community for helping with and planning for the library project; foremost among these is the director of the Alaska Medical Library Project, M. Walter Johnson, M.D., better known as the Clinical Director of the Alaska Native Medical Center. His ceaseless efforts have made the project a reality.

As a part of all RMP programs, advisory groups have been established to represent community interests. The Alaska Medical Library Advisory Committee was formed as soon as grant approval had been received. It is the function of this committee to make recommendations regarding library policies and procedures, and to approve any proposed changes before their implementation; it will also be responsible for evaluating the project and reporting its findings to the WARMP Central Staff. The committee consists of six physicians, two of whom were appointed by the president of the Anchorage Medical Society, two by the president of the Alaska State Medical Association (neither of these within the Greater Anchorage Area) and two by the Area Director of the Alaska Native Health Area Office. For those wishing to communicate with anyone of these committee members or the library, names and addresses are given.

This, then, is your Alaska Health Sciences Library, established for physicians and allied health personnel in Alaska. USE IT.



Alaska Health Sciences Library  
Alaska Native Medical Center  
P. O. Box 7-741  
Anchorage, Alaska 99501    Tele. 277-3511 Ext. 342

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## DR. CHAO HONORED

A man who has probably treated more tuberculosis patients than any other physician in Alaska was recognized recently for his work by the Alaska Tuberculosis Association.



On April 5, Dr. Richard Chao, Assistant Chief of Medicine for Tuberculosis at the Alaska Native Medical Center in Anchorage, received the citation at the annual dinner of the association from Larry Sullivan, executive

director. The occasion marked the first time the association has given the award, a framed certificate and a specially designed plaque, to a physician.

Born in Shantung, China, the 58-year-old physician was formerly a public health officer in Nationalist China. He studied at the Yale School of Public Health and came to Alaska in 1952. He worked first at the Tuberculosis Sanitarium in Seward, where he treated a large number of Alaskans during the early days of the crash program against tuberculosis. He is a commissioned officer in the USPHS.

Dr. Chao joined the staff of the PHS Hospital in Anchorage in 1956 and has served there since that date. During the past 16 years, he has seen a remarkable decline in tuberculosis in Alaska.

In his position at the Medical Center, Dr. Chao supervises the tuberculosis ward and conducts a very busy chest clinic. He is an ardent supporter of the INH chemoprophylaxis program.

Dr. Chao's wife, Dr. Chi Mei Chao, is engaged in the private practice of anesthesia in Anchorage. The couple have six daughters.

# MUKTUK MORSELS

## FAIRBANKS

Dr. Robert Hanek of Wisconsin, recently with the USPHS in Tanana and Sitka, has joined the Fairbanks Clinic in general practice.

The Greater Fairbanks Hospital Association has now raised an astounding \$1,750,000.00 in local donations and pledges, with the able fund raising assistance of the Lutheran Society of Homes and Hospitals of Fargo, North Dakota. The actual hospital planning starts shortly, and it is hoped that construction can begin next year. The proposed site is near Lathrop High School and is on the Hospital Reserve Land of the city and the borough. As it is above the recent high water mark, it will be built by carpenters rather than shipwrights.

Interim planning is not yet complete but the city will apparently have to take over St. Joseph's Hospital when the Sisters of Providence leave in July. It is hoped that the Lutheran Society will agree to operate this antiquated structure under some temporary arrangement with the city, until the new structure is completed for them.

## KODIAK

Dr. Mildred McMurty married Mr. A. Copeland of Kodiak last winter. She is keeping her former name in her practice.

## KENAI

Dr. Robert Stelle of Juneau has joined the Peninsula Medical Center and opened a full time office in general practice in Kenai. Dr. Peter Hansen has opened a solo office in general practice here.

The Peninsula General Hospital Board is actively continuing the search for money to complete construction of this much needed facility on the booming Kenai Peninsula. Apparently they are about the price of one large helicopter away from being ready to open.

## HOMER

Dr. George G.T. Leih is closing his office here and plans to enter a psychiatric residency at Central State Griffin Memorial Hospital on July 1. (Box 151, Norman, Oklahoma 73069).

## ANCHORAGE

Dr. Richard Curtis left Seward and joined the Doctors Clinic for six months pending the start of his Ob-Gyn residency at the University of Colorado. Dr. John F. Lee of Aberdeen, South Dakota, a board certified general surgeon, has been appointed Director of the Alaska Native Health Area Office. He replaces Dr. Holman Wherritt who has been appointed Assistant Director for the Division of Indian Health. Dr. Wherritt, who has been assigned to Anchorage since 1961, will now be stationed in Washington, D.C. Drs. Jean and John Chapman plan to open an office in general practice here in June. Dr. John Chapman (Rep.) will run for the State House of Representatives this year. Dr. Edwin C. Kraft is leaving the Anchorage Clinic in July to take over a mission hospital in Southwest Uganda (Ishaka Hospital, 75 beds, 40 miles from Mbarara) where he will be the Director and only surgeon. Dr. J. Ray Langdon has been reappointed to the Western Interstate Commission for Higher Education (WICHE) Mental Health Council. He reports that Dr. A.B. Collyar, formerly with the Arctic Health Research Center, is now Commissioner of Health for the State of Oklahoma. Drs. Edward Voke and Paul Dittrich passed their orthopedic boards in January. Dr. Michael Hein had a second son on February 29.

A recent groundbreaking by Sister Barbara Ellen at the Providence Hospital marked the start of construction of Alaska's first cobalt therapy unit. The unit will be built by free union labor with donated materials at contractors cost and will be equipped through an RMP grant. This impressive community support was organized under the auspices of the American Cancer Society, by a group headed by George Grimes, past President of the Anchorage Chapter, and Dr. Bruce Wright. Both men are Alaskan Delegates to the Regional Medical Program Advisory Council.

## CORDOVA

Dr. J. Ronald Brown, who practiced in Cordova from 1961 to 1964, has completed his residency training in plastic surgery and has opened a private office in that specialty in Kailua, Hawaii.



A monthly visit by different Washington State radiologists to Juneau has been arranged through RMP. The EKG transmission facility that was planned has not been funded. One nurse who attended a five week training course in Washington on coronary care unit nursing is now back at St. Anne's Hospital. The new 3 million dollar Juneau Hospital complex will officially start with a groundbreaking planned for October, 1968. Dr. Jean Chapman is closing her medical office here on Memorial Day.

## SITKA

Dr. William C. Charteris, 64, died in Sitka on April 30. Dr. Charteris, who for many years was the only physician and surgeon in the area, practiced in Sitka from 1936 to his retirement in 1961. He was formerly Sitka mayor and city councilman. Dr. Ted Philips has a general practice preceptorship program now under way in Sitka, in affiliation with the University of Colorado Medical School. Under this "Rural Preceptorship Program for Medical Students", an elective rotation of one or more months is made available to 4th year medical students. He shares responsibility for the functioning of the preceptorship with Dr. George Longenbaugh. Similar arrangements have been made in Wrangell.

Dr. David Dale now has his first University of Colorado student in training. These men certainly deserve congratulations in making this learning experience available. It is not unreasonable to expect that their efforts, as well as those of Dr. Paul Isaak in Soldotna, will help provide a continuing supply of qualified physicians for Alaska, in addition to enriching the curriculum and medical understanding of the students involved.

## KETCHIKAN

The Regional Medical Program plans to provide various lecturers from Washington State to make the Ketchikan, Juneau and Sitka tour every two months. A series of telephone lectures from the University of Washington is also planned, starting in June, and educational T.V. tapes have been made available if facilities for viewing can be arranged.

The new wing of the Ketchikan General Hospital should be completed in July. This will eventually result in an additional 40 long term nursing beds becoming available, although only 20 beds will be installed initially.

## MEETING NOTICES

American College of Legal Medicine, Professional--Clinical Meeting, San Francisco Hilton Hotel (check hotel bulletin board for meeting room), San Francisco, California, Sunday, June 16, 1968, 2 to 5 p.m.

Theme: Medical--Legal Problems with the Patient in Mind; Arthur H. Coleman, M.D., LL.B., F.C.L.M.--Moderator; The Doctor as a Malpractice Plaintiff, J. Harold Williams, M.D., LL.B., F.C.L.M.; Is Blood a Service or Product to the Patient? Panel: Robert

R. Morris, M.D., F.C.L.M., Quinn Jordan, LL.B.; The Changing Abortion Laws--Impact on the Patient, David W. Louisell, LL.B., Professor of Law, University of California; Pronouncing Death for the Heart Transplant Donor, Arthur H. Coleman, M.D., LL.B., F.C.L.M.; General discussion and questions from the floor.

Banquet 6 p.m. To the fullest extent, Speaker, James L. Goddard, M.D., Commissioner of Food and Drugs, Food and Drug Administration, Washington, D.C.

# STROKE SURVEY ANNOUNCED

By Marion Hoff Johnson

A number of physicians from the Anchorage, Fairbanks and Juneau areas will be interviewed this month (June) by medical students from the University of Washington on stroke care.

Internists and general practitioners, selected at random, were invited to participate in the survey sponsored by the Washington/Alaska Regional Medical Program to assess the diagnosis, treatment and rehabilitation of stroke victims cared for at home, in nursing homes and in hospitals.

At present information on stroke victims is usually obtained from hospital records. By deriving data from physicians it will be possible to compare how stroke patients treated at home and in nursing homes fare with those treated in hospitals. With a more complete profile of stroke care in Washington and Alaska, medical

communities will be able to plan more effective programs to meet the needs of their patients.

The Regional Medical Program (Public Law 89-239) was created to assist health care professionals in developing projects which will speed developments in stroke, as well as heart disease and cancer to physicians and their patients.

Results of the 25-question survey should provide a cross-section of the incidence of stroke in major medical communities as well as show the range of severity from the transient ischemic attacks to the rapidly fatal episodes.

Physicians will be asked about their views on present stroke care and future possibilities for diagnostic and treatment improvements for patients in their own geographic area.

The stroke survey has been approved by the Alaska and Washington State Medical Associations.

## LOCUM TENEMS SURVEY COMPLETED

In April of 1968, all Alaskan physicians were queried on their need for locum tenems coverage. Almost one-half of these men replied. Response analysis included the community post-marked.

Several interesting facts were confirmed by this study. All physicians responding from communities with a population under 2,000 have used a locum tenems in the past and plan to again. In the communities with a 2,000 - 10,000 population, one-fourth of the physicians have used, and one-half would like to use, a locum tenems, while in the communities over 10,000, one in ten has used a locum tenems, and one in three hopes to.

In all, 27 physicians indicated that help in securing a locum tenems would be appreciated. Almost all of these men preferred coverage for two weeks or longer, several expressing interest in three or four month periods. Twice as many men wanted coverage in the summer and fall as in the winter and spring, and all indicated that the free time would be used for a combination of purposes.

Three men preferred a straight salary arrangement for every one who suggested a percentage arrangement, and over one-half felt that about \$500.00

per week was equitable for an average size practice, depending upon the experience and abilities of the covering physician. Less than one-half of those responding believed their own medical liability insurance could be modified to cover their substitute. The rest felt that insurance must either be provided by, or purchased for the locum tenems. Several men felt that the current difficulty in obtaining liability insurance presented a real obstacle to getting competent coverage, one believed that it was an insurmountable problem.

Two-thirds of the physicians wishing help offered the use of their own homes for living quarters, the rest felt that satisfactory housing could easily be arranged.

The Washington-Alaska Regional Medical Program office is setting up a roster of those in need of locum tenems coverage, and is trying to recruit as many men as possible who would be interested in providing such short term help. Any physician interested in either aspect of this program may contact Levi Browning, M.D. at the W/A RMP Office, 332 L Street, Anchorage, Alaska 99501.



# ALASKA'S HEALTH REFERRAL PROGRAM

By Jean Dementi

*Public Health Nurse*

*Coordinator, Health Referral Program*

Many young men who are medically rejected for military service are unaware of the reasons for their rejection. In 1965, Congress authorized the Public Health Service to provide a counselling and referral program for all persons who do not pass their physical examinations at the Armed Forces Examining and Entrance Stations (AFEES).

Each State governor designates a single agency to handle the program, and in Alaska the Greater Anchorage Area Borough Health Department has this function. One public health nurse is assigned to the Health Referral Program. She is present at the AFEES as the young men return from their examinations. Each rejectee has the privilege of accepting or refusing the service, and if he accepts, he signs a waiver allowing the nurse access to his records. Most of the men are anxious to know more about their physical condition, and very few decline help.

The nurse reviews the physical examination of the young man with him, explains his disqualifying defects, points out his normal physical findings, and when necessary suggests possible sources of help for his problems.

Some of the young men have documented care-affidavits from physicians showing that they have had care. However, many are completely unaware of their defects until this pre-induction physical is done.

Among Alaskans, both native and non-native, the most common reason for disqualification is hearing loss, and most frequently this is from neurosensory damage due to noise. Some men do have hearing loss from scarred tympanic membranes or chronic otitis media, but high-frequency hearing loss is even more common. The nurse spends a lot of her time explaining the mechanics of this type of loss, and instructing in the prevention of further damage by the use of ear plugs when firing rifles, etc.

Other common defects include obesity, hypertension, hernia, asthma, internal derangement of the knee, active tuberculosis within the past five years, ulcers and refractive errors. If the rejectee has a private physician, a referral is made to that resource, and a copy of the physical examination is sent to the doctor. If the young man has no physician, he is given a list of doctors from which to choose, or if he is from another community, he may be referred to the nearest

Health Center for a list. Appropriate literature is available to help instruct the rejectee.

Because the Anchorage AFEES serves all of Alaska, many of the rejectees come from remote villages. If they are eligible to receive care at the Alaska Native Medical Center, they may go there, and if their condition needs diagnostic work-up, they may be admitted for as long as necessary.

For many, this is their first trip to "town", and their first chance for adequate medical care. The public health nurse makes arrangements for their clinic appointments and often transports them to the hospital.

Some of the rejected men seem to be very satisfied with their disqualification, but more of them express disappointment. For many, the bottom drops out of their world when they find out they can not enter the Service. Much of the nurse's time is spent in trying to help them understand why their particular disability rules out military service for them. These men may be referred for Job Corps, Vocational Rehabilitation, or Neighborhood Youth Corps if they are interested.

When a referral for care has been made by the nurse, she may keep that man's record open for a maximum of six months. During that time she checks with the physician and with the rejectee to see if there has been follow-through on her recommendations.

The Health Referral Program is in no way connected with the Selective Service Board, nor are any reports made to them. The program is aimed only at better health for this important age group. Strangely enough, however, the public health nurse is often asked by the rejectee if she can help him get the necessary care to meet the military requirements. One resource which proves useful under such circumstances is provided by the military. About a year ago, a list of certain remedial defects was drawn up. A young man with one of these problems may enlist, be inducted into the service of his own choice, and have his defect repaired at Uncle Sam's expense - after induction, but before basic training.

Does the Health Referral Program accomplish anything? Our records show that it does. A few results have been dramatic; more often there is just a better understanding of a condition which may or may not have been previously known to the young man.



*Left to right: Lena Young, Diane Brown, Marion Lampman, Maxine Cramer, Sunny Dunn, Earline Sturgis, Sherry Jaeger and Tarwanda Staller.*

## MEDICAL ASSISTANT GROUP FORMED

**By Theresa Thurston**

*Publicity Chairman, AAMA*

The Greater Anchorage Area Chapter of the American Association of Medical Assistants, Inc. was organized in February of this year. It is an educational organization sponsored by the Anchorage Medical Association and the Alaska State Medical Association to increase the proficiency of medical assistants in secretarial and management techniques. Membership is open to those persons working under the direct supervision of a physician.

A national representative, Mrs. Sunny Dunn, of San Mateo, California was present at the first installation ceremonies of officers held at the Anchorage Westward Hotel. She assisted Miss Lena Young, liaison officer for AAMA, with the installation of the officers of the Anchorage Chapter, who will also serve as founding officers for the Alaska State Association of the AAMA. Elected were Miss Maxine Cramer of the Langdon Psychiatric Clinic, President; Mrs. Diane Brown,

medical assistant to Alistair Chalmers, M.D., Vice President; Miss Marion Lampman, medical assistant to Levi Browning, M.D., President-elect; Mrs. Earline Sturgis, medical assistant to Frederick Hood, M.D., Recording Secretary; Miss Sherry Cheeney, medical assistant to Paul Dittrich, M.D., Corresponding Secretary; and Mrs. Tarwanda Staller, medical assistant to Sam Gibson, M.D., Treasurer.

With the formation of the State Association, we hope to organize chapters in Juneau, Fairbanks, Seward and other Alaskan cities. The Anchorage Chapter has about 30 members. All those who became members at the installation were registered as charter members of the new organization. Monthly meetings will be held at 8:00 P.M. on the third Thursday. All interested persons are urged to attend these meetings and for further information may contact Maxine Cramer at the Langdon Psychiatric Clinic.



# REVIEWS OF RECENT BOOKS

## AEROBICS or Fitness Through Oxygen

By Jack K. Lesh, M.D., M.P.H.

Chief, Branch of Child Health

Alaska Department of Health and Welfare

"Say, Doc, am I in good enough shape to try those 30 points of exercise I've been reading about in some of the magazines lately?"

Questions like this will be put to Alaskan physicians frequently, we predict, by fitness-seeking Alaskans who want to "keep in shape" both in everyday life and for their forays into the country's big outdoors. These persons will have been stimulated by a newly published book enigmatically entitled "Aerobics" by Kenneth H. Cooper, M.D., M.P.H., Major, USAF Medical Corps (M. Evans & Co., N.Y.; also Bantam Books); or by advance excerpts in This Week Magazine (mid-April, 1968) and Reader's Digest (March, 1968).

Optimal delivery of oxygen to all parts of the body is the basis of Doctor Cooper's theory of conditioning, hence "Aerobics": The graduated endurance exercises lead eventually to many bodily changes which he summarizes as "training effect", said to be the combined result of increased efficiency of lungs and heart; increased number and size of arterioles; increase in total blood volume; enhanced muscle tone, and loss of fat (though not necessarily total body weight); additionally, achievement of training effect results in greatly improved psychological outlook.

Doctor Cooper's Air Force flight surgeon career has been largely dedicated to the study of exercise physiology and physical conditioning. His access to large groups of military men and outstanding laboratory facilities made possible extensive studies of the conditioning process which led to a prescription for fitness for any individual. "Aerobics" presents Doctor Cooper's prescription along with some breezy text extolling the advantages of physical fitness and many individual testimonials to its benefits. Physicians will enjoy skimming through this book, but since it is aimed mainly at readers without medical or scientific background, they will occasionally yearn for confirmatory data to support some of the statements. No revolutionary or truly controversial evidence or claims are presented, but the well-accepted benefits of the conditioning process undergone by all outstanding athletes is tailored to fit all of us whose lives are primarily sedentary.

The importance of fitness is always tacitly recognized but needs continued emphasis. Doctor Cooper's effective presentation should entice many readers to

take steps toward better health through physical conditioning. The importance of prior clearance by a physician for individuals with medical problems is emphasized, but the program offered is adaptable to persons with almost any disability.

"Aerobics" stresses "endurance fitness" in contrast to most other popularized conditioning programs which Doctor Cooper says lead only to "muscular fitness", better than no fitness but only a small part of the optimal state. Calisthenics, the foundation of these other programs, play no role in aerobics training. Instead, one engages in increasing amounts of exercise requiring more or less prolonged exertion of the entire body. Running is the prime activity, but substitution of swimming, cycling, walking, handball, squash or basketball is allowed for variety and interest. These activities are pushed to tolerance according to schedule over a specified period of time.

One of the most useful aspects of the program presented is its ability to quantitate "how much" and "how fast" should an individual seek to achieve the fitness he desires. Physicians have rarely been able to answer such questions very satisfactorily, but now may use Doctor Cooper's tables as a guide for their patients. Before beginning this exercise program, each person takes a simple endurance test consisting merely of walking as far as he possibly can in 12 minutes. The distance he achieves then classifies him in a five-category fitness scale ranging from Very Poor to Excellent. Different training programs are then prescribed according to the initial fitness state, each leading to the achievement of training effect which can be sustained by a maintenance program of 30 points of exercise each week.

Each activity is awarded points according to how strenuous it is and how long continued. Points in any one activity may be exchanged for equivalent points in another to adjust for individual tastes and circumstances. The point definitions are simple and easily understood so each individual can readily determine and record his weekly point scores and know his progress.

All of us who are dedicated to promotion of good health for all Alaskans must stress physical fitness and "prevention" of illness. Differing approaches can and should be used. For many, aerobics may be the answer, providing the motivation to begin a fitness program and a simplified guide to its beneficial continuation.

## SURGERY OF THE AGED AND DEBILITATED PATIENT

Edited by John H. Powers, M.D.

Published: W. B. Saunders Co., Philadelphia 1968  
611 pages \$19.00

This book represents the collected opinions of twenty-four authors on Problems of Surgery in the Aged Patient. The editor is John H. Powers, M.D. and the contributing authors are for the most part Professors of Surgery in East Coast Medical Centers. This volume is a symposium approaching the subject from the point of view of physiology, metabolic management, nutrition, anesthesia, infection, psychology, and surgery of various specialized conditions. The section on metabolic management of elderly surgical patients by John Olson and Francis D. Moore is an extremely concise and authoritative discussion of this subject. Most of these topics are discussed by their authors in a thorough and authoritative fashion. As in most symposia there is considerable repetition and covering of the same material from only slightly different view points.

One of the precepts of my surgical training was "Age is no contraindication to Major Surgery". I accepted this statement with many others as part and parcel of the information that I had to know to complete my residency. As I have seen more surgical patients, I believe that what this aphorism really means is "Age is no contraindication to Major Surgery, but the older they are, the more trouble you can expect". I believe that this latter point of view is well documented by the various articles in the book under discussion. Most of the statistics indicate a higher incidence of complications, morbidity and mortality for operations in people above the age of seventy. I believe the main point of the book is that these problems may be managed with an acceptable degree of success if they are appreciated and handled with care and thought.

This text is one which might be valuable for reference, but certainly it is not something you would curl up with by the fire on a long winter evening.

By Theodore Shohl, M.D.

## THE SHARPEST NEED IN A TWO-PRONGED PROGRAM

There are two kinds of Peace Corps doctors.

First are salaried staff physicians, whose primary job is taking care of the health of Peace Corps Volunteers.

Second are Volunteer doctors, who, like all Peace Corpsmen, receive a small living allowance and devote all of their time to working with the people of the country in which they serve.

Today, however, the most important job of medicine in the Peace Corps is that of the staff physician. This is because Congress recently cut short the Corps' major source of staff physicians by eliminating draft exemptions for Public Health Service doctors serving with the Peace Corps.

Agency director Jack Vaughn has said, "Continued health care of our Volunteers is essential to our survival." Whether you are a mid-career doctor or recently retired, if you have stamina and sensitivity, a two-year staff position abroad is open to you.

For further information, write Dr. Stanley Scheyer, Director, Office of Medical Programs, Peace Corps, Washington, D. C. 20525.

## EPIZOOTIC OF RABIES IN ALASKA

A growing epizootic of wildlife rabies in and around the Northwestern area of Alaska with irregular distribution over other parts was reported for the first quarter of 1968 by the state Public Health Laboratories branch. A total of 18 cases of rabies had been confirmed as of March 31. Red fox accounted for 11 of the cases, Arctic fox for 6 and a dog for 1 case.

The fox remains the primary reservoir of rabies virus in Alaska, the report stated. Outbreaks of the disease were reported this year at Barrow, Kotzebue, Scammon Bay, Nome, Ambler and Wales. No human cases were reported among the persons bitten. No human rabies deaths have occurred in Alaska since 1945.

According to Surgeon General William H. Stewart of the U. S. Public Health Service, 1967 was the first year the United States has been free of human deaths from rabies originating within its borders. He also commented concerning the large numbers of laboratory-confirmed animal cases in the nation during 1967 and that an estimated 30,000 people were treated for rabies exposure.



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**Volume 10, Number 3**

**September 1968**

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# ALASKA MEDICINE

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# LEVI M. BROWNING, M.D.

## 1904-1968

By James E. O'Malley, M.D.

Levi M. Browning, M.D. was born in a small farming community in Benton, Illinois, September 3, 1904 and passed away on the 30th day of July, 1968 at the Lackland Air Force Base Hospital in Texas, of carcinoma of the lung with complications.

Dr. Browning completed his pre-medical require-

ments at the University of Illinois in Champaign and Urbana, Illinois. He then entered the College of Medicine at the University of Illinois and graduated in 1930. After his internship at Augustana Hospital in Chicago, he went to the Milwaukee County Hospital in Wauwatosa, Wisconsin, where he was Junior and Senior Resident in Surgery from 1931 to 1936.

I first met Levi Browning as a freshman in medical school in 1930, when he was an instructor in Anatomy at the University of Illinois College of Medicine. Shortly after this, he entered the U.S. Army Medical Corps. He served in various places in the United States and in the Far East. He had two tours of duty here in Alaska. The first was when he was Commanding Officer of the 183rd Station Hospital in the Army which was located on the grounds of the Fort Richardson Military Reservation. During this tour the Air Force was formed as a separate service and he transferred to this branch of the Armed Services.

Dr. Browning was in charge of the Medical Department of the United States Air Force Academy for a time at Colorado Springs, Colorado. He assisted in designing what is now the 5004th Air Force Hospital at Elmendorf, and was Commanding Officer of this hospital for several years before he retired.

Colonel Browning was appointed Commissioner of Health and Welfare for Alaska by Governor William A. Egan during his second term, a position that he fulfilled with great distinction. His administration was marked by the full cooperation of staff and no scandals.

With the change of administration he became associated with the Presidents Committee on Heart, Cancer and Stroke. During his period with the Regional Medical Program, the Regional Medical Library in Anchorage, Alaska was founded at the Alaska Native Service Hospital, complete with a librarian and staff. Construction of Alaska's first Cobalt Therapy unit was also started while he was Executive Secretary of the Alaska R.M.P.

He was well known and respected in the Medical Corps as a most competent surgeon, a trouble shooter of great ability, and lastly and most importantly, a most competent diplomat.

Alaska is unfortunate that we did not have him with us longer.







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Anchorage, Alaska



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By James A. Lundquist, M.D.

This is a year of challenge -- for medicine, for the State, for the Nation. It is interesting to note that the origin of the word challenge in the Latin *calumniare*, to accuse falsely, is especially applicable to the position in which the physicians of this country find themselves today.

This is truly a time of challenge, a time in which the foundations of the nation are being shaken by an administration which tolerates and even rewards insurgency and rebellion in our major cities; a time in which defiance of the law by large numbers of people is encouraged while the liberty of the individual is threatened. This is a time in which we are not safe walking the streets or travelling the highways; a time in which we spend more money for police protection and yet see our efforts thwarted by leniency in the courts, a leniency that protects the criminal and leaves his victims with no protection at all. This is a time in which the emotionally disturbed are featured performers on television, in which they are praised by the press, their activities encouraged by feature articles in the nation's periodicals, when these people should rather be encouraged or even compelled to seek psychiatric treatment.

This is a time when the common man's freedom is restricted more and more; we are in the strange position of fighting a war thousands of miles beyond our borders to secure for others a freedom that we ourselves may have no longer. In polls the people say 13 to 1 that they want government expenses cut rather than taxes increased. Yet we have a tax increase, and the government increases expenses, hires thousands, adds bureaus, continues to squander millions on such silly things as a study of East African monkeys. Three-quarters of the farmers of the United States want the government to take its hands off farming, to save the

billions now spent on what is called "farm aid", to let the farmer run his own business, but the government increases its farm budget to 6-1/4 billions and adds 1400 employees to the Agricultural Department. WHAT HAPPENED TO GOVERNMENT OF THE PEOPLE, BY THE PEOPLE, FOR THE PEOPLE?

This is a time in which our system of providing medical care -- the most successful the world has known -- is challenged to an extent that, unless the tide is turned NOW, the practice of medicine, as we have known it, will exist no longer. Our profession has made more contributions toward lengthening the life and improving the health and comfort of our people than has any other group or organization -- yet we are attacked by THE ATLANTIC MONTHLY, by LOOK magazine, by Martin Gross in his book, THE DOCTOR, by Martin Mintz in his book, THE THERAPEUTIC NIGHTMARE, and by others. The federal government is engaged in an attack upon the practice of medicine and is becoming more and more outspoken in its efforts to control the practice of medicine. With the fragmentation of the medical profession by specialty boards of ever narrower outlook we have even come to the point of arguing among ourselves over which specialty has the right to treat the patient.

Our use of drugs is controlled ever more strictly by a department of government whose recently-resigned head suggested that the use of marijuana not be restricted because the use of alcohol is not, but who roundly condemned the sale of candy cigarettes as being dangerous. Recent FDA rulings on the indications for and the contradictions against the use of certain drugs are such that the physician is liable for suit if he prescribes certain drugs even when their use may be lifesaving.

Our practice of medicine is more and more controlled by a federal government that in its infinite wisdom recently purchased, through the Agency for International Development, \$24,000 worth -- 13,635 gallons -- in vials -- of sea water from an agency in Italy to be used in the treatment of nausea and of skin eruptions in South Vietnam.

Because of the peculiarities of the courts and the

"something for nothing" philosophy promulgated in this country since 1933 the physician must limit medical treatment to that permitted by FDA ruling or by legal precedent rather than use as a determinant the patient's welfare; he must take unnecessary x-rays for his own protection not that of the patient; he must order unnecessary laboratory procedures against the threat of malpractice suit, the greater number of which appear to be unjustified from a medical point of view.

It is startling to note that the medical profession, the one group of persons in the United States who fought against the Medicare program on the grounds that such a socialistic scheme would bankrupt the economy, is now blamed, as costs skyrocket, for the economic failure of the very program which it did not want and against which it fought so hard. Soon Medicare will freeze our fees, not because of any abuse of the program by the physicians, but because the social planners need a scapegoat for their underestimation of the costs of the program. In spite of the failures of the overly costly Medicare program we are now faced with expansion of the program to include greater numbers of the people and the expectation that physicians' fees will be set entirely by the government. We are faced with absolute control over our fees. A Princeton economist recently predicted that regional fee schedules, covering all doctors and all patients, private as well as Medicare, are on the way. This economist urged that doctors seize the initiative and negotiate to prevent a unilateral imposition of fee schedules.

Dr. Martin Cherkasky, director of New York's Montefiore Hospital, stated recently in a Senate hearing on medical costs, that "fee for service medical care should be phased out", that prepaid health services be provided for all and that "all doctors should be on handsome salaries in hospital-based group practice". Most of us practice now in a group of some sort; the concept of group practice is being changed gradually by government effort to that of prepaid, closed panel practice: the first step is salary for all physicians and the loss of the fee-for-service principle, the second step is the loss of freedom of choice of physician. All socialism involves slavery; it is more the patient that will be socialized than the physician.

In recent history we can see that medicine has been one of the first fields of endeavor to be socialized or

nationalized. I suggest that this is in part because of the drama and emotion tied to health and illness, and in GREATER part because physicians, while men of principle, are not always men of courage. We must have the courage of opinion and not the temerity to give a political blank check to the administration in Washington. Politicians are able to think only of the next election; we must think of the next generation. Honesty, personal motivation, intelligence or ability cannot come through legislation; in medicine at least these can come only through liberty and through freedom of choice and action. We -- organized medicine -- must answer the challenges in no uncertain terms, make our position known, and be prepared to resist absolutely any scheme that takes away the freedoms which this nation once held dear, which tends to destroy the great system of medicine developed in this country.

We must achieve unity and understanding among ourselves to the extent that we can effectively tell the public of our ideas and convince the public of our ideals. We must unite to fight a battle which, if lost now, can never be fought again. We should not be reformers, dogooders, advocates of any alien philosophies or political dippy-doo, but rather honest practical men, making an effort to practice medicine in an atmosphere of freedom, giving of ourselves to treat human ills. We must at all times make the welfare of the patient our first concern. Organized medicine has not failed the physicians of this nation; it is the physicians who have failed by not joining with their colleagues to fight that which we know to be wrong. What have you done to strengthen medicine's position in this time of challenge? The practice of medicine is changing; we must master and direct its change.

The Alaska State Medical Association is small in membership; perhaps we might expect it to be difficult for us to change the course of things, but I am convinced that there are here extraordinary possibilities. Our strength comes in our being a small and relatively unified group having a closeness of interest and living and working in a geographically isolated state. Our efforts, even to the point of an absolute boycott of government programs which we believe to be contrary to the best interests of our patients, can be the beginning of a trend back to the freedoms we began to lose 35 years ago.



# COOPERATIVE THERAPY FOR A NATIONAL PROBLEM

By Milford O. Rouse, M.D.

*Past President, American Medical Association*

*Presented at the banquet of the Alaska State Medical Association Annual Convention, Anchorage, June 7, 1968*

When history looks back on the period we live in today, to assess its relative significance in the field of medical achievement, there is some question as to how this time might be evaluated.

If students of the future apply the criterion of over-all discovery for the most widespread benefit, they could put this in their records as the era of new vaccines.

On the other hand, if they judge it by spectacular achievement in the handling of spectacular conditions, this might be recorded as the era of the heart and other human organ transplants.

But if they should measure medicine's preoccupation during this period by the number of square feet of written material or the number of hours spent in discussion of some subject, this can only be designated as the era of community health planning.

There has never been anything in the history of medicine quite comparable to this phenomenon.

It is next to impossible for physicians to get together today without spending at least part of their time discussing community health planning--whether the getting together is of a thousand physicians at a national or regional congress; of several hundred at a state association; of a few dozen at a county society; or of three at a table for lunch.

Interest in the subject is not limited to physicians. The topic also appears on the agenda of many other organizations, including those in all of the other areas of health care plus those of business, government, education and a host of others.

I do not point out these things in order to ridicule or criticize them. On the contrary, I think it is a wonderfully healthy thing--and no pun is intended.

There is no subject more worthy of consideration by all of society than the health of all the people of our nation.

No organization is more eager than the medical profession to cooperate in whatever steps can be taken to help assure that the level of health in our nation will continue to rise. After all, that's what physicians are here for. For several thousand years, physicians have been trying to keep people in good health.

We aren't likely to change that objective now just because other people have also become interested in it.

What the expanding interest means to us is addi-

tional responsibility, because now we must not only continue doing all of the things we would be doing anyway; but also must help guide the activities of newcomers to the field so that planning in which they participate, can be done in a way that is reasonable, workable and in the best interests of patients and society as a whole.

There are many ramifications to our responsibilities in planning, but I want to touch particularly on one of them.

People in government and in many other areas of society who are new to the area of planning for health and medical care, indicate that they believe good health is something that can be purchased for a whole society or for given segments of society.

And they profess to believe that good health is something that can be provided for people under certain established circumstances.

We who have been in medicine for a long time know that such a concept is impossible. One of our important planning responsibilities is making that impossibility clear to others with whom we are working on planning programs.

That is not to say, of course, that nothing can be done. On the contrary, a great deal can be done and has been done to raise the over-all level of health in this nation, and to make it available to all citizens.

In the last year alone, the amount and the nature of medical progress were outstanding, as they have been every year.

For example, the first heart transplants were performed. How soon that technique will prove successful and more widely available, is an unknown factor.

Progress continued in the transplantation of other internal organs, including the kidney, the liver and the pancreas.

Probably the most significant breakthrough in science in 1967 came in December when two physician-biochemists announced that they had synthesized a DNA virus that was viable. This discovery might one day make it possible to cure such hereditary disorders as hemophilia, muscular dystrophy or PKU (phenylketonuria). It would be impossible to over-emphasize the potential importance of this one discovery.

Let me very quickly list just a few of the other advances in the field of scientific medicine last year.

Sixteen new single-ingredient drugs were accepted by the FDA and introduced to physicians for the benefit of their patients.

In connection with the worldwide problem of population control, indications began to appear that a "second generation" of contraceptive drugs is on the horizon, providing female infertility for long periods of time.

Measles vaccine proved so effective that there were fewer cases of the disease during the first half of 1967 than in any comparable period since measles record keeping began in 1912.

A vaccine for mumps was accepted; and a German measles vaccine is expected to be available within two years. Also in the experimental stage were vaccines to immunize children against streptococcal infections and to eliminate the RH-negative problem in mothers.

As important, probably, as the individual scientific discoveries that help overcome specific problems, are the advances that have been made throughout the history of this nation in providing over-all conditions of cleanliness, sanitation and purity in our food.

But there is a paradox in this. With all of the advances they have made, and all of the work they are doing, physicians cannot provide the final answer to health for the individual. Only the individual himself can do that.

Medical science is helpless in the face of opposition or lack of cooperation from the patient. No wonder drug will correct a condition if the drug is not taken as prescribed. No treatment will cure a disease if the patient fails to undergo it. No person's body is going to maintain itself indefinitely in a state of health unless it is treated properly, fed properly, rested properly and exercised properly.

Many people appear too busy with other things to take care of their health. Apparently they expect doctors to do it for them. But a physician can't provide good health to a person any more than a teacher can provide an education for a student who doesn't work at it.

Let's consider first the highly intelligent people who bring their problems to us daily.

They know that exercise is vital to maintain proper muscle tone and to promote general good health. Yet they get into their 300-horse power cars to drive two blocks to the drug store. They go to the golf course for exercise, and drive from green to green in a motorized cart.

They know that too much body weight increases the work the heart must do. But they continue not only eating too much, but concentrating on rich, fattening foods because they taste better.

They know from evidence published from many sources that smoking certainly is not good for them and most likely is quite harmful. But they continue to "light up" because the habit brings them momentary pleasure.

They know that the use of alcohol can lead to the disease of alcoholism that can destroy a man and his family. Yet people in this country continue to spend more money every year on alcoholic beverages than they spend on private education and research.

They know that automobile accidents have killed more people in this country than all the wars fought by the United States. Yet they continue to demand cars with higher horse power and greater speed...and drive them without regard for the laws of the highway or the simple rules of safety.

The list could go on. But to summarize briefly, it has been pointed out that average life expectancy in this country probably could be a hundred years if we would all live as we should and stop killing ourselves and each other with too much smoking...too much drinking...too much careless driving...too much eating of rich foods...and too little exercise.

All of these problems are vastly multiplied when we leave the upper and middle economic classes and turn our attention to the poor. But the causes of the problems change.

In changing the focus of our attention, we move our concentration from the ranch houses of suburbia that characterize the lives of the vast majority of people in this nation...to the tenements and incorrectly called "ghettos" or slums in which live the small percentage who have been unable to participate in the social and economic improvements that have been made year by year or who manifest no interest in preparing themselves to so participate.

Whether the fault lies in all of society or in these people themselves really makes little difference. If we are to manifest our faith in our Judeo-Christian traditions, we cannot ignore the plight of these people just because their number is statistically insignificant when compared with the total population.

They are in a deplorable situation and they need help in learning to live a better life and in making themselves able to do so.

These are people who do not face the problems of overeating. By contrast, many of their children receive only one reasonably good meal a day which is given to them in school.

These are people who do not merely overlook the amenities and healthful advantages of cleanliness. On the contrary, some of their children are permitted to



take a shower one day a week in their public school because their homes have no bathing facilities.

It is obvious that the health of such people is not good.

The question that we are being asked every day by outsiders; and the question to which we devote so much of our time; is this:

"What can the medical profession do about it?"

The answer is clear:

"Pitifully little or nothing... if we are expected to do the whole job alone."

That is not a denial of our responsibilities, nor is it a refusal to do what all of us know must be done. It is a simple statement of fact, recognizing that the problems of the poor are so complex that they cannot be solved by any one profession, or any single organization, or through any one unique approach.

I think it's time we started making our position and our responsibilities perfectly clear, both to our friends and colleagues and to our critics.

Health has become the primary subject -- indeed, almost the exclusive subject -- upon which most of the current observers of the slums are heaping their criticism. They are demanding of the medical profession and its allies in the health care field not just that something be done; but that everything be done, and be done immediately, to establish supremely good health among all of the disadvantaged and deprived people who live in the unspeakable conditions of the slum areas.

They expect this to be done without consideration for any of the other elements of slum life.

Expecting the medical profession, or anybody else, to single out one problem in the big city underprivileged areas of this nation and solve it without changing all of the conditions that contribute to it is the same as asking a group to build a house in the midst of a hurricane.

People who are demanding the solution of a single problem are pretending to be concerned, and pretending to take action, which salves their conscience. But it is the same kind of over-simplification as giving a Christmas basket of canned goods to a starving family and then ignoring them the rest of the year.

Because health -- or the lack of it -- has become the darling of the welfare planners and even of the conscientious observers who wish to improve life for the desperately poor, the medical profession has become the favorite whipping boy of all of them.

Almost overnight, if we are to judge by publicity, by the statements made inside and outside of government, as well as by legislative proposals offered almost daily within congress and by the national admin-

istration, it appears that physicians and their allies are to be blamed for the deplorable conditions of the slums.

Let us make clear that while we willingly accept our portion of responsibility for the health of all citizens of this nation, we do not accept the blame for circumstances which are entirely beyond our control. The slum areas have been developing for two centuries. We did not invent them. And I would urge the people who want to correct the slum conditions to seek answers to questions like these:

Who owns the building that have become tenements and slums, housing many times more people than they were designed to hold?

Why are there no sanitation laws limiting the number of families that can inhabit a building, an apartment or even a room? Why are there no health laws requiring that in the middle of the city, buildings inhabited by human beings must have toilet and bathing facilities?

If there are such laws, who has ignored them for a century?

Who has permitted buildings and whole neighborhoods to deteriorate to the point where rats and insects run freely through them literally feeding on the human beings who also live there?

Who is responsible that there is no garbage collection in those neighborhoods and that trash and organic waste pile up in the alleys as breeding places for every conceivable carrier of disease?

Who is responsible for the fact that there is no public transportation available to the people of these areas so they can conveniently go anywhere in the city they wish to go for health care or any other service?

Who is responsible for the fact that generation after generation of these unfortunate people have little or no education?

Who is responsible for the fact that generation after generation of potential breadwinners among these people have not obtained training for even the most menial of jobs, with which they could earn self-respect along with a living?

Who is responsible for the fact that many of these people are so lacking in motivation and so lacking in ambition that they fail to take advantage of even the most accessible avenues of help that are available to them?

I cannot answer all of those questions. I do know, however, that those many conditions are not the fault of the medical profession. And the solution of the health problems of those people -- which, as all of us know, requires a great deal of cooperation by the patients themselves -- cannot be attained until all of

the other conditions that contribute to their poor health also have been corrected.

We cannot build our house until the hurricane has passed.

Instead of being everyone's scapegoat, we of the medical profession want to be everyone's real partner, so that, together, we can build an edifice of stone that will withstand the hurricane.

We want to work with all other groups, agencies, organizations, professions and individuals who want to mount a practical attack against the total problems of the slum areas. That attack cannot be limited to the problem of poor health or the lack of immediate health care. It must simultaneously attack problems of housing, sanitation, adequate diet, education, motivation, employment and a host of others.

The attacking army cannot be limited to the medical profession or the other allied professional groups in the health care field. It must combine the efforts and resources of government -- especially at the local level, but including state and federal -- with those of the health field, civic groups, educational groups, religious denominations, philanthropic organizations, labor unions, employer associations, industries and all other elements of our complex society.

Priorities must be established, and all of our efforts must be coordinated into an effective, long-range program. Experts in each field must attack their own area, while coordinating their efforts with all of the others who are engaged in the total problem.

Solving any single problem is impossible without solving all of them, because there is an interdependency among them. Decent housing means little to people who have no job. A decent job is unattainable without education. Education is difficult, if not impossible, among people whose mental alertness is dimmed by the physical weakness of inadequate diet. And so it goes. Each problem adds to the difficulty of all the others.

Regarding the specific health problems, it would be ideal to say -- let's build a fine new clinic in every neighborhood in the United States and fill it with the very latest and most sophisticated equipment for diagnosis and treatment.

Even if there were enough money in this country to do that, and there isn't, there aren't enough personnel to staff them. We are well aware that the entire health care system in our nation is suffering from shortages of medical professionals and the skilled allied professionals who serve with them. Just as we are seeking new systems of providing health care throughout our land, we must look for solutions in the underprivileged areas which will work with the present

number of people, while steps are being taken to increase that number.

Two problems may be noted: making presently existing health care facilities more readily available to people in slums; and teaching the people to take advantage of the services that already exist.

I believe a prime need is to establish referral centers in poor neighborhoods, to be staffed by volunteers who are well-informed on what is available. A person needing help, whether medical or otherwise, could go to the center and find out where his specific need can be met; and find out how to get there.

A companion step is to make transportation available, free or at low cost, so that help of all kinds becomes reasonably accessible to the people. This can be done by cities' providing new special-rate bus routes; or by private means, through religious, civic or other organizations. Such groups could establish schedules of volunteers to provide the needed transportation for people wanting to go to a health care institution, physicians' office, government office or other location.

Establishment of such things would have to be part of the undertaking of a total educational program for slum dwellers. They need basic literacy training; they need basic health information; and they need a multitude of other kinds of training and instruction to help them pull themselves into the mainstream of social and economic progress.

Whether through neighborhood meetings or individual visits with families, these people must be shown two things: first, how they can help themselves; and second, that they must help themselves because nobody else can do it for them.

No amount of money can create jobs. They have to be created through the private efforts and expansion of business and industry. No amount of money can buy job qualification. The people themselves must prepare themselves, with help, of course. No amount of money can buy education. The people are going to have to learn.

And as I indicated in the beginning of this discussion, no amount of money and no amount of superb medical care as such can make people healthy. Health cannot be given to anyone. Help can be given when it's needed. But over-all health is primarily a responsibility of the individual. That is particularly crucial in the slum areas.

Those people don't live in an environment that is conducive to good health. Just as it doesn't do any good to bathe a child and send him out where he must play in the mud: it doesn't solve the problem to treat

*Continued on Page 147*



# ALASKA'S NEW McLAUGHLIN YOUTH CENTER

By J. Scott McDonald

*Commissioner of Alaska Department of Health and Welfare*

On July 13, 1968 the 49th State became the 50th State in the nation to establish its own training institution for juveniles. On that date the George M. McLaughlin Youth Center was dedicated as a co-educational school for boys and girls whose involvement in trouble with the law is so deep seated as to require 24-hour residential treatment and supervision. The Center is headed by Superintendent Howard Leach and has the mission of receiving, studying, treating and reporting on boys and girls ordered into its care.

Mr. Leach receives broad policy decisions, guidance, administrative and logistical support and funding through the Division of Corrections, within the Department of Health and Welfare, of which Mr. Raymond May is Director. It is strategically located in the vicinity of the Alaska Psychiatric Institute and the Providence Hospital in Anchorage thus making the services of these institutions readily available to the Youth Center. Its residence capacity is 120.

Prior to McLaughlin's opening, Alaskan boys requiring institutional commitment were sent under contractual agreements to state and federal facilities in California, Utah, and Colorado, while girls generally were placed in convents of the Good Shepherd in Washington and Montana.

An unusual Center responsibility, not found in most facilities of its type, is the provision of a juvenile detention program for all children living in Alaska's Third Judicial District. This part of the correctional process was not intended for the Youth Center. Because of the demands for this service, it has been temporarily undertaken, even though the philosophies and methods for detention as compared to treatment are quite different.

Associated with detention as part of the receiving program are services at studying boys and girls early in their commitment to the Center. The study is being accomplished through the use of a clinical team. Team members include a Social Worker assigned to each group living section, a Psychologist, a Teacher, Group Supervisors working in the particular dormitories, and in special cases a Psychiatrist. Coordinating their efforts, these professionals work together to reach conclusions and recommendations that answer the questions: "Why did this youngster get into trouble?" "What can we do through the school program to help him stay out of trouble?"

An important facet of the Youth Center's functions

is to formulate a Clinical Report. This report will follow the youngster through his or her career, and will be extremely valuable for institutional personnel, courts, classification committees, and probation and parole officers working with the youngster until final discharge.

Basically, the McLaughlin Youth Center is directed at producing attitude change... rather than surface conformity to exterior pressures which evaporate when these pressures are removed. Change at this level comes through motivation gained from residents seeing that they have an attitudinal problem involving law and order, and from recognizing that its manifestations work against their own self-interests. The Center's program attempts to provide the ingredients needed for change through two lines of inter-dependent programming.

The first line of programming concerns activities... school, work, and recreation. The Center requires that residents meet such responsibilities by acting increasingly out of themselves. Attitudes are revealed by focus upon what a person does out of himself. In contrast, attitudes may easily be concealed by conformity to what another person directs. Therefore, by gradually forcing a youngster to assume more responsibility on his own, a resident's personal attitudes toward responsibility become increasingly apparent, and subject to examination for their meaning to his life.

The second line of programming includes various individual and group counseling activities. These provide the means whereby a resident can see and work out the significance of problems revealed by his participation in Center activities.

A major means of reaching these ends is organization of the Center's residents into small living groups whereby the impact of both lines of programming is enhanced.

Living groups consist ideally of from six to eight residents who live together in the same area, and are charged as a group with performing as many responsibilities realistic to Center life as possible. Organizing residents in this way provides the following advantages:

(1) Living in small groups enhances identification with the Center: The principle here is the same as that realized by a student in a large college. He feels less lost as part of a small group which gives the larger program meaning, than "rattling around" as an independent in the same program.

(2) Group living provides increased opportunities for friction: Work responsibilities handled by residents working together create friction around the attitudinal problems of the residents involved. Working in a group also causes such attitudes to be witnessed by other residents. Such peer-witnessed attitudinal problems provide both meat for counseling, and a strong way of reinforcing their implications for the resident involved.

(3) Group living leadership responsibilities cause residents to work with others in the very areas in which they typically have difficulty: No one can give forceful leadership in working through areas wherein he himself is uncertain. Accordingly, boy and girl leaders will experience the greatest difficulty in leading groups through just those problems where they are most identified with delinquent points of view.

Therefore, being forced to assume leadership roles in groups as a condition to graduating from the Center program causes boys and girls to actively face up to and work with their own identification with delinquent points of view.

(4) Group living meetings provide an additional avenue to that of counseling, wherein residents may recognize and work through problems.

(5) Group living responsibilities provide a small society wherein it can be realized first hand that controls must be present in community living, or certain individuals will "mess it up" for everybody: A living group which is honestly given responsibility for its own living conditions finds that the controls it must assume have much in common with those imposed by

"law" upon the citizen in the street. These responsibilities include seeing that members:

- (a) Are counseled regarding rule violations and their implications for the group's welfare;
- (b) Wear clean clothing;
- (c) Meet prescribed standards of appearance and bodily cleanliness;
- (d) Adequately care for laundry;
- (e) Use of unit recreational facilities is not abused;
- (f) Appreciation of the integrity of person and property is maintained;
- (g) Standards of behavior are met in situations where group control is reasonable.

Progress in the program is measured by resident ability to do increasingly well in work, counseling, group living, and general activities in four successive steps. Increasing responsibilities in each of these areas must be completed before the next can be undertaken. No minimum or maximum time must be spent in each of the four step levels with two exceptions. Movement to the first step, that of Center Citizenship, requires a minimum of two weeks... and the four steps as a group cannot be completed in less than 14 weeks. The average stay for most residents will be from seven to nine months.

Although Alaska was the last state in the nation to establish its own training institution for juveniles, Alaskans can take great pride in the fact that its Youth Center's program is of the highest quality having capitalized on the mistakes and lessons learned by other states that have preceded us in this venture.

July clinicians in the Anchorage and Fairbanks areas included Major General Robert Shira, Chief of the U. S. Army Dental Corps. Dr. Shira presented one of his excellent lectures on oral surgery and related topics, in his own inimitable style. The occasion was part of a world-wide inspection of facilities trip for General Shira, and he gave far more than he received, as usual. His last visit to Alaska was some seven years ago when he appeared on the program of the annual meeting of the Alaska Dental Society.

Dr. Harry W. Archer, Professor of Oral Surgery and Anaesthesia, School of Dentistry, University of Pittsburg, also presented an illustrated lecture to the combined civilian and military dentists of the Anchorage area on the "Surgical Treatment of Oral Cysts".



Dr. Frank N. Dorsey, General Shira  
and Dr. Robert A. Smithson





# AURORA DENTATUS

R. A. Smithson, D.D.S.

## FLUORIDATION

Fluoridation of community water supplies in Alaska continues to progress with active educational efforts currently being conducted in Seward, Alaska by Dr. Dick Williams and in Homer, Alaska by Dr. Bill Marley. This major preventative measure is feasible in most of our communities, and of course, considerably less dollarwise than the cost of repairing the ravages of dental decay in non-fluoridated dentitions. The effort required in some towns is considerable, and the dentist must assume the leadership in each case. Situations are always different, but with thorough specific researching and the enlistment of local physicians, public health nurses, health councils and concerned parents, virtually any community can enjoy this major health benefit.

It is interesting to note that there are now six states: Connecticut, Minnesota, Illinois, Delaware, Massachusetts, and Michigan that have enacted legislation requiring fluoridation of municipal water systems. Kentucky is attempting to do likewise.

Colorado makes funds available to assist in purchasing and installing fluoridation equipment in economically depressed municipalities.

In Iowa, towns of 2,000 population or less are offered up to \$750.00 in matching funds. The total cost of installations of this size is about \$1,500.00.

Tennessee's matching fund program has so far resulted in the fluoridation of some 30 small towns.

Drs. Williams and Marley promise more on this in the near future.

## HISTORY OF ALASKAN DENTISTRY

The American Academy of the History of Dentistry has inquired for source material on Alaskan dentistry. There is a paucity of our history in writing, which some believe to be just as well; but recording the important developments of our profession as they occur becomes more meaningful as the years go by. For the present, at least, the editor will be pleased to receive any his-

torical data that may be in your files. Any form would be acceptable, but comments or a narrative in your words would be helpful.

## CONTINUING DENTAL EDUCATION

Many of Alaska's dentists will be able to take short courses in or near their hometowns this year. Culminating some two years of discussion and planning, the first course will be given by Dr. Norman Olsen on Pedodontics for the General Practitioner. It will be held at the Anchorage Westward Hotel, October 4 and 5. The fee is \$75.00 and the course will qualify for 16 Academy of General Dentistry credits. Dr. Tom Lewis, Director of Continuing Dental Education, University of Washington School of Dentistry, has developed an impressive array of courses throughout Washington and the Northwest, and now has three scheduled for Alaska. The second will be "Better Radiology Techniques", February 28, March 1 in Juneau by Dr. William Updegrave. This is during the Mid-Winter Meeting. Number three is "Detection and Early Diagnosis of Oral Cancer". April 28, back in Anchorage. CDE is completely self-sustaining, and deserves whole hearted support from Alaskan dentists.

## COMPREHENSIVE HEALTH PLANNING

This new phrase in our vocabulary can be loosely defined as step one in the formal socialization of the Health professions. Not many people in private or public health are certain what the exact results will be, nor the mechanisms, funds, etc. Some work is being done at the State level, some at the local level, most of it without specific direction. It is basically setting up statistics to justify another give-away program or to qualify for matching funds. Currently the Lil' Abner comic strip depicts the situation.

The Greater Anchorage Area Borough is preparing to take a Special Official Census which will contain the same data as the General Census. Census takers will be trained starting October 1, and the data will be collected by November 1. The results will be available next year, which will be very useful in the obtaining of grants, matching funds, budget allowances, etc. of the many and varied Federal, State and Borough Agencies and Departments. This will precede the figures of the 1970 Census by at least 18 months and will apparently be well worth the additional expense incurred. Incidentally, this will be bought with unexpended Borough funds, there is no Contingency fund left.

This Census data will be worked up by statisti-

cians, blended with data obtained from the hospitals in the area, questionnaires which will be filled out by the dispensers of health (physicians, dentists) then evaluated and interpreted by a Planner for Comprehensive Health.

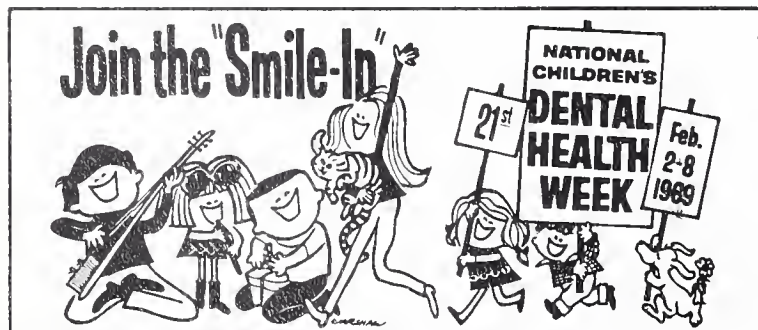
Federal funds for Comprehensive Health Planning expire in 1970, so next year will be the decisive one.

#### ALASKA DENTAL SOCIETY RELIEF FUND REPORT TRUST FUND ESTABLISHED

Dr. Craig Kauffman informs us that preliminary approval has been secured from the Anchorage Office of the Internal Revenue Service for the establishment of an indenture of trust for the Society's Relief Fund. Final decision from the Tacoma office is expected soon. This will create a special and separate tax-exempt trust, set up along the guide lines and following the rules of the American Dental Association Relief Fund. Its purpose is to help truly destitute dentists or their dependents. All grants by the ADA Relief Fund are matched by our State Fund, however, the State may make its own grants if so desired. The maximum period of assistance is one year, but if re-applied for, the grant may be renewed. The fund has some \$1,700.00 at present.

#### SPECIAL TO DENTAL PRESS

Chicago -- Special materials for use during 1969 National Children's Dental Health Week are now available from the ADA, Miss Dolores E. Henning, assistant director of the ADA Bureau of Dental Health Education, has announced. The NCDHW's 21st anniversary observance will be held February 2 through 8, and materials include television spot announcements, radio transcriptions, scripts for use on radio or TV, outdoor advertising posters, car cards, miniature posters and window displays.



#### KETCHIKAN

The Jimmy Whaleys are nesting again... another little one is on the way.

Wally Connell is back at Loyola studying Orthodontics.

Jim Van, recently from California, is currently officing at the previous Connell address.

President Aubrey Stephens is scheduled to attend a meeting in Seattle on behalf of the Society; topic: Dental Service Corporations. Should be interesting and helpful to us in the future.

#### JUNEAU

Archie Stewart has retired. The boys had a party for him and wished him well, as do all of us. His plans are to remain in Juneau, with maybe a little Sun-Break p.r.n.

Plans are forming for the Mid-Winter meeting in March. Details on the accompanying Extension Course of the University of Washington Dental School will be forthcoming.

#### FAIRBANKS

Carl Higgins has joined Bud Fate in his office. Says he loves Fairbanks.

Lee Ellenberg is spending two days a week with Bob Willey, commuting from Anchorage, where he is establishing his own office.

Arnold Pflugrad is getting things settled down in his new office.

#### ANCHORAGE

The Anchorage Dental Research and Educational Group starts their Fall schedule this month.

The Federal Bar Association has invited the South-Central Dental Society to lunch at which a film, "Jeopardy - A Story of Dental Malpractice" will be shown.

The Nominating Committee will report at the regular SCDDS meeting September 19 at the Sheffield House. Dr. Eugene Short of Anchorage Community College will speak on the Dental Assistants Training Program.

Belton Stephens, Oral Surgeon covering surgical emergencies for Anchorage, will discuss Pathology of Oral Soft Tissues at a Section Meeting, Anchorage Community Hospital, September 18. Dr. Stephens recently passed the Alaska State Dental Board.

John Kobylarz has recently established his office in Anchorage.



# ADDRESS DELIVERED BY SENATOR ERNEST GRUENING, M.D.

## TO THE ALASKA STATE MEDICAL ASSOCIATION

### JUNE 5, 1968

Dr. Wilkins, Dr. Tower, and Members of the Alaska Medical Society:

It gives me a peculiarly nostalgic and pleasant feeling to be addressing, I think for the first time since I graduated from Medical School, a group of members of my former profession. I want to say that those four years in Harvard Medical School were certainly not wasted years. Although I decided then to leave the care of the human body for attention to the ills of the body politic, and although I did not know what was going to happen at the time, I have never regretted the wonderful education I got then, and I have appreciated its usefulness in subsequent years of my government service.

We are living in a period of tremendously rapid change, perhaps the most rapid change in the history of mankind. Moreover, it is a steadily accelerating pace of change. The many revolutions that we signalize as being contemporary, includes the political revolution which seems to be taking place at home. For no less an authority than Associate Justice of the Supreme Court, Abe Fortas, in an article in the New York Sunday Times, eight weeks ago, declared that our country was now in revolution. I doubt that this revolution has hit all parts of our nation, but certainly we are passing through a period of turmoil, disturbance and violence. And whatever be its ultimate outcome it has some very sinister and unhappy connotations.

But one of the several revolutions taking place on earth, the revolution in freedom of thought, has more promise for the welfare of mankind. One of its important facets has to do with contraception. Contraception as a recently emerging and pressing issue is intimately related to the great recent advances in medicine, surgery, pharmaceuticals, dietetics, sanitation, because it is to those great scientific gains that the current and mounting population crisis is in part due.

I first became interested in the need for birth control as an undergraduate in Harvard Medical School. In our third year we went out on obstetrical service in the slums of Boston. I would there see large families living in great poverty and even squalor, with the mother often sickly from excessive child-bearing and the children coming out at regular intervals every nine or ten months, many of them in poor health. I came to realize then that birth control was a real need, and that it would enhance the level of family life. Something had to be done to give these parents the opportunity at least to determine how many children

they wanted, and at what intervals. This was an extremely radical, advanced and wholly proscribed idea at that time. Contraceptive techniques were not taught in medical school. I soon found how perilous promulgation of this idea was, when somewhat later as the managing editor of the Boston Traveler, I wrote an editorial indicating the desirability of modifying existing State legislation which prevented dissemination of birth control information even by physicians, and even when the life of the mother might be at stake. Such legislation was practically universal throughout the United States. In the editorial I sought to point out the desirability of modifying the law and making family planning information available. However, this purpose was deemed so subversive by the publisher and by my boss, the editor of the morning paper, the Herald, that the presses were stopped and my offending editorial extracted. Somewhat later when I went to the Boston Journal, as managing editor, I had a freer hand. I did write such an editorial. It was not taken out, but resulted in the cancellation of a lot of advertising. Birth control was really a taboo subject at that time. And it continued to be a taboo subject until very, very recently.

Then in the late teens, I got to know Margaret Sanger, the pioneer in this field and a woman of great courage and vision. It was she who expressed the view that "it is time to lift birth control from the gutter of obscenity into the light and dignity of human reason." My wife, Dorothy, and I were members of the First American Birth Control Conference which took place in New York City in 1921. Margaret Sanger was scheduled to appear at Town Hall to discuss birth control. The mere discussion of the subject was considered so obnoxious by certain powerful religious groups that the meeting was raided and closed by the police, although no contraceptive devices were to be given out and no current legislation violated. Mrs. Sanger was merely going to discuss the general desirability of making contraceptive information available to those who wanted it, and modifying existing legislation to make this possible.

The years passed, and I found myself in 1934 in the capacity of Director of Territories and Island Possessions of the Department of Interior. I was also given the additional assignment in 1935 to be the administrator of the Puerto Rico Reconstruction Administration. Puerto Rico was in very bad shape economically at the time the "New Deal" came in,

following the great depression of the late 20's and early 30's. Puerto Rico had some 350,000 unemployed. A Federal Government revolving fund was created to try to relieve that situation. I was placed in charge of it. So we started all the various projects that put people to work: housing, slum clearance, rural electrification, following construction of power dams -- all useful and needed undertakings. They included a new plant for the University of Puerto Rico.

At the end of nine months, we had put 60,000 people to work. Those 60,000 breadwinners -- considering the size of the Puerto Rican families -- really ended unemployment. Then it occurred to me that in the next nine months there would be an increase in population equalling the number we had employed. So while we had temporarily checked unemployment and stabilized the Island's economy, we were actually really not making any permanent progress. So I felt that we ought to do something about the increase in population. I decided to establish some maternal welfare clinics where mothers, who had had seven, eight and nine children but preferred not to have 10, 11 and 12, could get the necessary information about birth control if they wanted it. We started this with considerable enthusiasm with a limited number of physicians and social workers because at that time there was very little knowledge of contraceptive techniques, even in the medical profession. Unfortunately the year was 1936, an election year. When word of this activity got back to National Democratic Headquarters, I was ordered to cease and desist from this activity. I was told the clinics would be very damaging to President Roosevelt's campaign for re-election, and that I must close the clinics. Who was I to impair the Presidential prospects?

So I sadly called together my staff of social workers and doctors and informed them of the high-level decision and that we could take no further part in it. But the clinics went on just the same. They went on because the Puerto Ricans themselves wanted them. In the following legislature, they repealed the restrictions against giving contraceptive information and appropriated funds to carry on the clinics. Those clinics have gone on ever since.

Well, this had become a different problem in our nineteen sixties than in the early days of this century. In those days our concern, my concern, and that of others interested in making contraceptive information available, was for the individual family, for the right of parents to be able to determine how many children they wanted and the right to have access to the necessary contraceptive information, if they wanted it.

But by mid twentieth century, the great advances

of which I have spoken in the various fields of the healing arts had produced an increasing disparity between the birth rate and the death rate. Today this is an entirely new aspect of the birth control issue; it is the issue of over-population.

The most striking statistic to demonstrate this is that it took from the beginning of time, from the most primitive cave man, from Adam and Eve, if you will, to 1850, to bring about a population of one billion people on our small planet. Now 118 years later, that population has nearly tripled. Unless we do something about it, it is destined to double in the next 30 years at home and abroad, creating a situation which will be utterly chaotic and impossible for mankind happily to survive.

It seemed to me in 1963 that we should do something about it. So I introduced legislation in the Senate in April of 1965.

S. 1676 was very mild legislation. It merely provided for two additional assistant secretaries in the Government: One in the Department of State to take care of the problem abroad; and one in the Department of Health, Education and Welfare to take care of the problem at home. The bill also called for a nationwide White House Conference on Population to discuss the subject. All was to be on an entirely voluntary basis. It was to prescribe nothing in the way of compulsion. No religious inhibitions were to be violated. It was really an exercise of freedom of information. Information was to be made available through these offices. Those who wanted to receive the information could do so. Those who wanted not to receive need not receive it, or having received it, need not utilize it. We got something of a break for our first public hearing on June 22, 1965. I received a letter from former President Eisenhower who had previously, when President, opposed any action by the government in the field of family planning and contraception. He had stated most emphatically as President that the federal government should not inject itself into the family planning field. He said it should be left to private groups such as Planned Parenthood. But he had changed his mind.

I heard of his change of mind and wrote him. I asked him to state publicly why his views had changed. On the day before this first Senate hearing before my Subcommittee, we received a very vigorous letter saying that he had completely changed his mind; that the limitation of population by birth control was one of the most pressing problems of our time and that the government should go into it actively.

Nevertheless, some of my solicitous friends warned me then that I was taking a very politically perilous course by raising this issue, by sponsoring the legis-



lation, and by holding public hearings on my bill. One of them said to me, "Ernie, you have committed political suicide." "Well," I said, "I hope not, but if so, so be it. This is too important an issue not to bring into the open." Since that time, there has been a tremendous breakthrough. Family planning is getting under way and it is being actively pushed now for the first time by Federal agencies in the Departments of HEW and State.

I was in Bethel just two or three days ago. The staff of the Indian Health agency is giving family planning information in the Eskimo villages. It is found that there is a desire for it, and that mothers, by the time they have had five or six children, are very happy to receive it. It is very clear that unless we do something about this, our world is going to face disaster. In our own country we now have a population of 200 million. If we don't check this increase, that population will double in the next 30 years. Then, unless we slow down, presumed further advances in surgery and medicine, will shorten that period of doubling so that possibly by the year 2025, we will have 800 million people here, and before the middle of the next century, a billion people. I am glad I won't be around if and when that happens.

This country will no longer be "America the Beautiful". Our resources will long since have been exhausted. We are running short now of water in many parts of the country. The open spaces - our forests and meadows - will disappear, America will become a vast urban sprawl.

It is particularly important that this prospective horror be brought home to all those who are concerned about the future, not only of our country but of all nations.

I think it is remarkable to see how quickly that breakthrough, that change in sentiment, is taking place. I reintroduced S. 1676 last year because when I first introduced it in the 89th Congress, I got adverse reports from the two agencies concerned, State and HEW. This, despite the fact that President Johnson had spoken forthrightly on this subject no fewer than 42 times up to and including his most recent remarks in which he has pointed out in various ways that money spent on Family Planning was more valuable than 20 times that sum spent in economic aid. It has been very apparent that our foreign aid programs have been undercut and largely nullified by the tremendous increases in population in the countries we have aided. No matter how many schools are built, the number is insufficient. This occurs virtually throughout the world. In the foreign aid field we are finally doing something about it. In the current Foreign Aid Bill,

we have earmarked \$50 million to spread the word, to make contraceptive technique available in those countries where the people want it. Everywhere this is always done on a voluntary basis. We properly stress that there is no element of compulsion. I hope that there will be a change in the attitude of those who have opposed it on the grounds of morality. Contraception is a much better alternative than abortion which takes place throughout the world, especially in Latin American countries. There are thousands and thousands of needless mothers' deaths and the resulting tragedies, because these deaths involve women who have not had contraceptive information. They have resorted to the more radical and tragic method of abortion.

We sometimes wonder that at the same time that we talk about progress that we see evidence of regress in various fields. I think it is particularly important that it be understood that the giving of contraceptive information where it is needed is the greatest promoter of morality and family happiness. We have all seen families go to pieces from excessive child bearing. The family is happy with the first, second and maybe the third or fourth child, but then when the fifth and sixth and seventh child come and the resources of the breadwinner are no longer adequate, quarreling and friction ensue ending in the breakdown of the family relationship and frequently in the breakup of the family. It can be very well argued that apart from its physical benefits there is a very great moral implication in this program provided it is clearly understood always that this is based on voluntary acceptance and that the method of choice is left entirely up to the individual recipients.

In the three years since the Senate Population Crisis hearings were started, we have had 31 hearings, and have heard over 100 witnesses. They include the most distinguished individuals you can imagine from every field of activity: medicine, housing, agriculture, law, demography, nutrition, sociology, economics, and four Nobel Prize winners who with some 70 others petitioned the Pope to change the Catholic Church's position on contraception. So far that position has not changed, but it is well known that within the church there is a good deal of dissent on the subject. We had in our hearings, a number of Catholics, including one priest, who testified very emphatically in favor of my legislation. Here is a revolutionary process taking place all over the world, the results of which, I think, cannot but be very beneficial. I am hopeful that we have started moving ahead to check the tremendous increase in population which will be disastrous both at home and abroad unless something is done about it.

Some of us are rather pessimistic. They feel that perhaps the battle is already lost, that the world already has more people than it can support and that we are fighting a rear guard action against almost inevitable disaster.

My nature is optimistic so I think it is not quite as bad as that. But I think we have to be conscious that there will be widespread famine and unrest beyond what we have experienced in the world today unless we slow down this acceleration in population growth.

This about sums the prospect, past and present, except to report that right here in Alaska there is good activity. The field representative of the Department of HEW, Dr. Bruce Jessup, has been asked to give an eight hundred thousand dollar grant to the State Department of Health. That is going to enable the promotion of education on family planning and the use of the necessary information and devices wherever they are needed and wanted.

Sometimes people wonder why Alaska with so small a population has a Senator interested in the population problem. Actually, I would say that one of the desirable aspects of life in Alaska is that we don't have too many people, that we are not as crowded as they are becoming in California; that we still have in our beautiful 49th State a great freedom of action and ample space, that we are not ants in an anthill as people are in some of the larger cities down below, and that our lack of

population, which we cannot hope to maintain forever, still presents a very beneficial contrast with some of the overcrowded sections elsewhere in our country and throughout the world. We do have a population problem among our Native people where it is clear that they are living in dire poverty in the areas to the westward, where they live at the very lowest levels of subsistence. They live perhaps in greater poverty and want than do the people of any other part of this nation. Here the giving of contraceptive information is of real tangible benefit. I hope that this may continue until our population is stabilized and until all parents have the freedom of choice to determine how many children they want and at what intervals.

Certainly there is no danger of so-called "race suicide", a phrase made popular in the days of Theodore Roosevelt by him, because I think it is natural, that nearly all people want children. Moreover, wanted children are the loved children and those destined to a greater happiness than those who come when they are not wanted.

Victor Hugo is credited with the aphorism that there is no force that can effectively cope with an idea whose time is arrived. I venture that this is true of contraception. Its time has arrived. Widely understood, accepted and applied, it will spell the birth of a new freedom for mankind and particularly for womankind.



**"THE INVADERS" by Fred Machetanz.**

*Collection of Mr. and Mrs. James Medema.*

*32x52 oil painting on masonite. This painting depicts a polar bear in the Arctic looking upon the first white people to penetrate his domain, presumably Capt. James Cook with his ships, the Resolution and the Discovery in August, 1778.*



# THE PHYSICIAN AND ABORTION LAW

By Peter J. Koeniger, M.D.

In recent months, articles on liberalization of abortion laws have been appearing with great frequency, both in medical publications, and in the lay press and magazines. This seems to be in response to an obvious change in the attitude of our society towards abortion, rather than an attempt by the press to foist a minority viewpoint onto an apathetic public.

Alaska is one of the majority of our States which permits abortion only to save the life of the mother. Our statute reads: "A person who administers to a woman pregnant with child any medicine, drug, or substance whatever, or who uses an instrument or other means, with intent to destroy the child, unless the action is necessary to preserve the life of the mother, is, if the death of the child or mother is thereby produced, guilty of manslaughter, and is punishable accordingly."

A person convicted of manslaughter is subject to imprisonment for one to twenty years; but no conviction because of abortion has ever been obtained in Alaska. Several cases have been investigated, and at least one case in southcentral Alaska was brought to trial. Evidence to prove attempted abortion seemed conclusive, but the prosecution was unable to prove that the abortionist had caused the death of a living child. This resulted in a directed acquittal of the accused abortionist.

With such a legal attitude, it would seem that the only possible way a conviction for abortion could be obtained in Alaska, would be in the case of a conscientious physician who hospitalizes a patient for a therapeutic abortion for which he feels there are strong medical indications, although not life-saving; who has recorded consultations from other physicians who agree that his patient's growing, intrauterine pregnancy should be interrupted; and who records on the hospital chart some evidence of a fetal heartbeat just prior to the abortion.

In 18 years practicing obstetrics and gynecology in Alaska, I can recall performing only four therapeutic abortions (excluding ectopic pregnancies); in each of these instances abortion was felt to be actually necessary for saving the mother's life. Yet I have probably taken care of well over eight hundred women undergoing abortions which I had not brought about. The majority of these have been spontaneous, but quite a few self-induced by the patients, and undoubtedly a fair number criminally induced by other individuals.

My experience is probably quite similar to that of

most other physicians doing obstetrics and gynecology. I can feel no special pride, however, in turning to therapeutic abortion so seldom. When I tell a patient who is begging for an abortion that I am sorry, but the law does not permit me to help her, I am using a legal technicality to keep myself from becoming involved in a difficult situation. In many instances I may feel as strongly as the patient that there are overwhelming medical reasons for not permitting the continuation of pregnancy. I should, as a thoughtful physician, be able to do what she and I feel is in the best interests of her health. When I turn her away, it does not mean that I saved some poor, misguided woman from a sin against morality which would have haunted her the rest of her life; instead, many times my refusal or legal inability to help such a woman has meant that she will subject herself to the hazards of unskilled criminal abortion, or if she has sufficient funds, that she will fly to Japan to submit herself to the ministrations of an unknown foreign physician.

On one occasion within the past year I was prepared to perform a therapeutic abortion, against the law, on a young mother with rubella in her fifth week of pregnancy. She was seen in consultation by another obstetrician and by her pediatrician, both of whom strongly advised interrupting the pregnancy. She happened to undergo a complete, spontaneous abortion on the day she had been scheduled to enter the hospital for dilatation and curettage. At least two therapeutic abortions have been done in Alaska for this same indication by other physicians - openly, with proper consultations, and in licensed hospitals, but quite definitely not in accordance with Alaska law. I am not sure if these physicians were aware that their action, while medically proper, was in violation of the law.

Having strict abortion laws may have seemed necessary to ease the Puritanical conscience of our society in past generations. Nevertheless, the public and its prosecutors have seemed to recognize the need for abortions for some indications other than directly saving a woman's life. As a matter of practicality, this need has generally been met by tacit non-enforcement of the law. At present, however, attempts are going on to pass more liberal abortion laws in many states.

Such attempts to liberalize our abortion law will certainly be in evidence in Alaska as well. A committee to draft a reformed abortion bill to submit to the next state legislature was set up by the Alaska State

Medical Association at its annual convention in June, 1968. Prior to this, the Alaska Council of Churches at its tenth annual assembly had also appointed a similar committee.

In many states, the model penal code adopted by the American Law Institute in 1962 serves as the basis for attempted abortion law revisions. This would allow abortion: 1. if there is substantial risk that the continuation of pregnancy would gravely impair the physical or mental health of the mother; 2. if the child would be born with grave physical or mental defect; 3. if the pregnancy resulted from rape, incest, or other felonious intercourse.

The American College of Obstetricians and Gynecologists at its annual meeting in May, 1968 issued the following statement on therapeutic abortion: "Termination of pregnancy by therapeutic abortion is a medical procedure. It must be performed only in a hospital accredited by the Joint Commission on Accreditation of Hospitals and by a licensed physician qualified to perform such operations.

"Therapeutic abortion is permitted only with the informed consent of the patient and her husband, or herself if unmarried, or of her nearest relative if she is under the age of consent. No patient should be compelled to undergo, or a physician to perform, a therapeutic abortion if either has ethical, religious or any other objections to it.

"A consultative opinion must be obtained from at least two licensed physicians other than the one who is to perform the procedure. This opinion should state that the procedure is medically indicated. The consultants may act separately or as a special committee. One consultant should be a qualified obstetrician-gynecologist and one should have special competence in the medical area in which the medical indications for the procedure reside.

"Therapeutic abortion may be performed for the following established medical indications:

"1. When continuation of the pregnancy may threaten the life of the woman or seriously impair her health. In determining whether or not there is such risk to health, account may be taken of the patient's total environment, actual or reasonably foreseeable.

"2. When pregnancy has resulted from rape or incest: in this case the same medical criteria should be employed in the evaluation of the patient.

"3. When continuation of the pregnancy would result in the birth of a child with grave physical deformities or mental retardation."

This says the same thing as the American Law Institute's model penal code; but the addendum permitting account of the patient's total environment to be

used in determining risk to health, would allow consideration of socio-economic factors as well as more strictly medical indications.

This statement of the College is not an authorization for a physician to carry out a therapeutic abortion against existing law. Perhaps, though, it may be considered by those involved in reform of present laws; and perhaps it may serve as one more stimulus for some physicians to press for reform of existing abortion laws.

The American Civil Liberties Union has proposed that all laws imposing criminal penalties for abortions performed by licensed physicians for whatever reason should be repealed. With criminal penalties removed, the decision whether or not to continue a pregnancy would become one of the woman's personal discretion and the doctor's medical opinion. In reply to the argument that to destroy a fetus at any stage of development is murder, the Union states that such judgements belong solely in the province of individual conscience and religion, which the state does not have the power to force on the entire community.

It would seem that such an approach to abortion laws should be espoused by more physicians. If therapeutic abortion is, as we claim, a medical procedure, then there should be no more reason for a law to define when this may or may not be done than for any other procedure in the practice of medicine. What would we, as physicians, think, if our legislators tried to pass a law making it illegal to perform an appendectomy unless the patient had fever, elevated white blood cell count and abdominal rigidity? I am sure that we would agree that such a medical judgement should be left in the hands of physicians instead of lawmakers.

Why not, then, allow the law to state that therapeutic abortion, when performed in an accredited hospital by a licensed physician with appropriate consultation with two other licensed physicians, is a matter of the practice of medicine, and is not subject to criminal penalties.

Would this lead to the abuse of the procedure by physicians? It seems most unlikely. About 80 per cent of the fellows of the American College of Obstetricians and Gynecologists approved the statement on therapeutic abortion issued by the College this May. It seems reasonable to assume that most other American physicians practicing obstetrics and gynecology hold similar views. In each accredited hospital, physicians now review the work of their colleagues, specifically including therapeutic abortions. Guidelines such as those in the ACOG statement would be used in judging the medical propriety of therapeutic abortions done

*Continued on Page 129*



# AN INQUIRY INTO PREDISPOSITIONAL FACTORS INCIDENTAL TO ACHIEVEMENT SUCCESS BY ALASKA NATIVE PEOPLE:

## A Preliminary Survey

By Ashley Foster, Ph. D.

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This preliminary survey sought to uncover some predispositional factors related to the achievement of success by Alaska Native people. If we could uncover some factors basic to this achievement, such knowledge could be used in planning programs for the Alaskan Native. If we could fathom the motivations and value system of the successful individual, we might alter some aspects of the Alaska Native's environment to make achievement a more common event in his life. In this study, success was arbitrarily defined as an achievement far beyond the average of the Native population in an area of value to Western society.

The Native people of Alaska have achieved far less than the generality of the United States population; economically as well as academically. Formal education is a relatively recent experience and, in many outlying areas of northern and western Alaska, completion of the eighth grade is a very recent event.<sup>1</sup> Most recent statistics indicate that the adult population averages between six and seven years of schooling<sup>2</sup> and that a little over half the population who entered elementary school in 1954 would finish.<sup>3</sup> A review of the Alaska Native attendance at the colleges and universities shows only 5.5 per cent of the eligible population enrolled.<sup>4</sup> Gross figures for the population of the United States show about 32 per cent of a comparable population in institutions of higher learning.

It was assumed then that a person who had finished high school and had enrolled in college fulfilled our criterion for success. Here was a Native person whose educational achievement made him unique. He had achieved measurably higher than 95 per cent of his fellows, and he was accessible for purposes of inquiry. The measurement of successful achievement in the trades or in business would entail problems of identification as well as definition and would have required greater subjectivity than this inquiry.

We assumed, then, that the Alaska Natives at a university were successful. Because they had advanced so far educationally, they were thought to have positive goals. Such an assumption made the academic environment a convenient locale at which to institute an inquiry.

At the university were many "successful" people in one location and criteria for success could be established with great precision. Additionally, a student group is more articulate than many Alaska Native people for whom English is too often, a second language.

### METHOD:

For this inquiry, 37 Alaska Native students in attendance at the University of Alaska were interviewed in February, 1967. Consistent with the general trend throughout the nation, ethnic self-identification is voluntary at the University. Except for those individuals who receive some form of categorical aid or belong to an ethnic association, ethnic grouping was either a matter of common knowledge or guesswork. It is quite possible for Alaska Natives at the University to be unidentified as such. A list of 46 Alaska Native student names was compiled, which lacked about 10 persons known to the Dean of Students. Of the 46, 37 were interviewed. They represented approximately two-thirds of the known Alaska Native students and were thought to be a fairly good representation of all Alaska Native students in attendance at the University.

The group was almost evenly divided, 19 men and 18 women students. Although they averaged about 20 years of age, the boys were almost two years older than the girls - 20.9 vs. 19.1 years old. On a four point grade scale in which A = 4 and D = 1, they averaged 1.86 in the first semester at the University while all university freshmen in the Fall of 1966 averaged 1.98. The men interviewed had done better (1.974) than the women (1.759) in their freshman semester. It should be noted that all of these freshman averages are below the grade of "C".<sup>5</sup> Our group represents the survivors of the first semester whereas the total college average includes all freshmen. The higher grade average for the men reflects the freshman averages of an older and, as we shall note again, academically longer lived group.<sup>6</sup>

With academic statistics as a criterion, our group who survived the first semester did not differ signifi-

cantly from either the general student population or the total population of Native students at the University. Their high school average varies only insignificantly from the averages of former classes, 1964 and 1965,<sup>7</sup> and the entering high school averages of all university students.

The student was queried on why people should go to the university and what school was doing for him. In addition, we sought his feelings on the desirability of leaving home for school, the amount of sacrifice warranted for a university education, and the value of a university education. We inquired too, why so few Alaska Native people went on to the university and what he thought was their appreciation of the university.

We were interested in the student's satisfaction with his educational experiences to date; what he expected the role of education to be in his future; and how he saw himself in the future, first in the vague abstract future and then specifically, five and ten years ahead.

The information was collected on two sheets of paper. The statistical information such as class, sex, occupation of parents, high school attended, etc. was entered on the first sheet and the interview record on a second sheet. The second sheet, without identification was reviewed separately while applying the following questions:

1. "Does the family feel that an education is necessary?"
2. "How would the subject feel if there were no schools to attend?"
3. "Is the school giving the subject what he wants?"
4. "Is education necessary for what the subject plans to do?"
5. "Does the subject seek an education from internal curiosity or is he being driven by external forces?"

This group of 17 freshmen, 10 sophomores, 9 juniors, and one senior, was interviewed with an open-ended questionnaire. In addition to the usual statistical information, the interview centered about four areas which were assumed to be significant to the determination of success in school: First, the parental views on the significance of education; second, the students' attitude on the nature and purpose of education; third, the satisfaction with the educational experiences to date and, fourth, the students' understanding of the relation between his education and his own future.

The interview was quite informal and the questions (Appendix A) were written as a guide for the conduct of the interview rather than to be repeated verbatim. Wherever possible, the questions were asked in an

indirect style to avoid answers in which one individual would seemingly pass judgment on another.<sup>8</sup>

The student was asked how his parents felt about his leaving home for an education and what importance his parents attributed to education. In addition, other sources of academic encouragement or discouragement were sought.<sup>9</sup>

Each person was rated by a minus, a zero, or a plus in each of the above categories. The last category comprised an overall judgment based on the total questionnaire. In it the minus represented external, and the plus represented internal, drive.

RESULTS:

Grouped by the school system last attended, there were 10 from the Bureau of Indian Affairs high school, 16 from various city and state schools, and 11 from various mission schools throughout Alaska. The city and state high school graduates were almost a year older, they had survived longer at college and they were performing about half a letter grade better than their confreres from the B.I.A. high school.

The mission and B.I.A. students did better in high school but the latter performed the poorest as college freshmen. Examination of differences in the freshman grades among the groups, however, shows no significance beyond the 10 per cent level of confidence. Percentage comparison by school system of all Alaskans between the ages of 6 and 18 with the numbers of students who subsequently attend the University of Alaska does show a very significant difference: the mission schools contribute disproportionately greater numbers to the college population. (Chart I).

CHART I  
DISTRIBUTION OF STUDENTS BY SCHOOL SYSTEM ATTENDED

	B.I.A.	City/State	Mission	Total
N	10 (27.0%)	16 (43.2%)	11 (29.7%)	37 (100%)
Average Age	19.3	20.31	20.27	20.0
High School grade point average	2.63	2.48	2.84	2.604
Freshman grade point average	1.51	1.95	2.04	1.86
Freshmen	6	6	5	17
Sophomore	1	6	3	10
Junior	3	4	2	9
Senior	-	-	1	1

Comparison of percent of Alaska Natives in schools by school system attended for the Fiscal Year 1966, ages 6 - 18, with the percent in attendance at the University of Alaska from these schools (Figures from the Bureau of Indian Affairs, Juneau.)

7,272 (40.9%) 9,635 (54.2%) 848 (4.7%)

Chi square with two degrees of freedom very significant at 0.5 per cent.

No significant correlation was found between freshman grades and family attitudes toward education. According to the students, five families discouraged attending college, 19 families seemed somewhat



neutral, and 13 families encouraged attendance at the University. (Chart II).

CHART II			
FAMILY ATTITUDES TOWARD EDUCATION			
	-	0	-
N	5	19	13
Average age	20.6	20.3	19.5
High School grade point average	2.793	2.583	2.576
Freshman grade point average	1.835	1.888	1.821
SCHOOL			
B.I.A.	1	5	4
City/State	-	12	4
Mission	4	2	5
CLASS			
Freshman	3	6	8
Sophomore	1	7	2
Junior	1	6	2
Senior	-	-	1

Predictably, there was a positive relationship between attitudes towards school and freshman performance. Despite almost a half grade point difference between those positively and those negatively disposed toward school, this difference is significant at only 10 per cent. (Chart III).

CHART III			
Distribution of students interviewed according to how they would feel if THERE WERE NO SCHOOLS TO ATTEND			
	-	0	-
N	14	4	19
High School grade point average	2.59	2.65	2.62
Freshman grade point average	1.61	1.82	2.05
SCHOOL			
B.I.A.	6	2	2
City/State	4	1	11
Mission	4	1	6
CLASS			
Freshman	7	3	7
Sophomore	5	-	5
Junior	2	1	6
Senior	-	-	1

Analysis of Freshman grade point average shows significance at 10 per cent.

CHART IV			
Distribution of students interviewed according to IS THE SCHOOL GIVING THE SUBJECT WHAT HE WANTS			
	-	0	-
N	10	14	13
Average age	19.7	20.1	20.2
High School grade point average	2.55	2.65	2.65
Freshman grade point average	1.58	1.69	2.26
SCHOOL			
B.I.A.	3	5	2
City/State	3	5	8
Mission	4	4	3
CLASS			
Freshman	6	9	2
Sophomore	3	2	5
Junior	1	2	6
Senior	-	1	-

Freshman grade point averages differ significantly at the 10 per cent level of confidence.

Upper classmen seem to be happier with their school. Students who are satisfied are slightly older, in a higher grade, and if the school they attended is any criterion, more urbane. They have advanced more rapidly and even as freshmen, have been more successful students than their fellow Natives. (Chart IV). Differences in freshman grades assume significance only at the 10 per cent level.

Answers to the question, "Is education necessary for what the subject plans to do?", show no significant differences related to entering freshman grade averages. (Chart V).

CHART V			
Distribution of students interviewed according to IS EDUCATION NECESSARY FOR WHAT THE SUBJECT PLANS TO DO			
	-	0	-
N	7	4	26
Average age	19.9	19.25	20.2
High School grade point average	2.54	2.52	2.66
Freshman grade point average	1.20	2.25	1.96
SCHOOL			
B.I.A.	3	-	7
City/State	1	3	12
Mission	3	1	7
CLASS			
Freshman	5	2	10
Sophomore	1	1	8
Junior	1	1	7
Senior	-	-	1

Analysis of Freshman grade point average shows no significant differences at 10 per cent.

The final review of interviews for a subjective answer to the hypothetical question: "Does this student go to school because he is internally motivated or is formal education for him the touchstone to greater

CHART VI			
Distribution of students interviewed according to whether they had INTERNAL vs EXTERNAL MOTIVATION TO SEEK AN EDUCATION			
	-	0	-

	-	0	-
N	12	14	11
Average age	19.5	20.21	20.36
High School grade point average	2.571	2.658	2.636
Freshman grade point average	1.672	1.792	2.210
SCHOOL			
B.I.A.	6	2	2
City/State	4	6	6
Mission	2	6	3
CLASS			
Freshman	7	5	5
Sophomore	2	5	3
Junior	3	3	3
Senior	-	1	-

Analysis of Freshman grade point average shows significance at the 95 per cent level of confidence. A combination of the-(minus) and the 0 (zero) columns shows significance at better than the 99 per cent level of confidence.

vocational opportunity?" disclosed a number of interesting factors. A statistical evaluation of the freshman grades among the three groups - positive, neutral, and negative - indicates that there is indeed, a significant difference among them. If, however, the externally motivated (minus) group were combined with the "neutral", i.e., not strongly motivated either way, the difference between the resultant two groups becomes very significant. In the simplest terms, there is a very significant difference in the freshman performance between those who say they want an education in order to learn more or to become better people, and those who want an education in order to get a better job than they might otherwise obtain. (Chart VI).

#### DISCUSSION:

The Alaska Native, particularly from the western portion of the State, is now in the process of a cultural transition from an aboriginal and primitive existence to a sophisticated technologic economy. He is being forced by economic need to bridge a cultural lag of several thousand years in order to acquire the many skills needed for survival. Just as he may not have a physical immunity to many of the western diseases, he also has not acquired a resistance to some seductive aspects of a Western society which bring him the artifacts of a technologic and commercially oriented civilization. The rifle, the gasoline-powered sled, and alcohol, for example, were quickly adopted. The Puritan virtues which have enabled Western man to exercise a modicum of control over the utilization of these symbols of better living, have been virtually ignored. This imbalance in attitude has within it some aspects of a philosophy which stresses a, "Live now and pay later", point of view.

The many years which are normally devoted to develop skills to pursue the good life, represent an effort generally foreign to the Alaska Native. Formal schooling itself, is relatively new to the Alaskan scene. The hypothetical benefits of education have caused sufficient disruption to the aboriginal life to keep schools from being viewed with universal favor by those being schooled. Schools have reduced the available work force and have helped to immobilize a hunting and fishing society, which historically moved in family groups to seek the wherewithal for life. The completion of elementary school is a recent experience for the Alaska Native and graduation from institutions of higher learning is rare.<sup>10</sup> An appreciation of formal education has not developed but has been imposed by an outside

authority. It is not a normal aspect of the Native Alaskan cultural milieu.

Formal education - as it appears to be seen by our group under study - offers little real promise for self-fulfillment or an enrichment of daily experiences. It offers some vocational promise which is often insufficient to warrant enduring the many years of discomfort needed to achieve the goal.

Because of the small numbers in this study, it would be fatuous to generalize too broadly, even though the figures have been subjected to some statistical analysis. This initial inquiry sought to find areas for profitable research on predispositions to success of a culturally deprived and economically backward people in the midst of a radical transition. The search aims ultimately, to reduce the impediments to successful living as the individual himself might intelligently and knowledgeably define that phrase.

Statistically, far beyond chance, the percent of students in the various elementary and secondary school systems is not comparable with the percent from these schools at the University. Explanations that the systems are not the same and that the students from these systems are not the same, are tenable. Students at the B.I.A. high schools are less urbane and they receive an education which is academically less demanding than that of city, state, or mission schools. These latter can stress a university-oriented secondary education more than their B.I.A. counterpart which must face the necessity to maintain a greater vocational effort. Students from the urban, state and mission schools seem better equipped to achieve more at the University and they are. These schools generally draw from a population which understands the realities of life away from the village. The urban Alaska Native has broken away from the traditional economy and he can understand the need for a formal education more than his rural counterpart.

The first major division based upon the response to, "Does the family feel that an education is necessary?", sought to explore the relationship between moral support from home and the students' success at college. Some parents resent the alienation from family and village which is often the inevitable result of education. Urban parents, however, do not experience so intensely this feeling of alienation. There is a marked, statistically non-significant, difference in the staying power of students from families with positive attitudes which might underline the belief that the urban population understands more clearly the relationship between education and worldly success.

The second question, "How would the subject feel if there were no schools at all to attend?" sought to



discover, if possible, whether the student had a positive desire for learning or whether he drifted on to the University as a course of least resistance. For many of the Alaska Native high school graduates, a return to the village life seems the least desirable of the several alternatives available to them; hence they will continue on to the University. Many students seem to drift to the University rather than to seek, actively, a university education. In more than a mere academic sense, they seem to be adrift.

Although ethnic social groups attempt to develop Native self-identification, they are not positive forces for the development of a rich academic life. The peculiarly Native organizations seem most concerned with the political potential of Alaska Native problems and do little to develop an esprit, a good social life, academic excellence, or a good university life.

The Native student appears to be unaware of the impact of national and international events upon his own life - apart perhaps, from his own draft status - and he is often unaware of the total requirements of his avowed academic goal as well as his future vocational goal. Students with academic problems often avoid the difficult classes rather than apply a more intensive effort or request assistance. Few students seem to have the conviction that success could really be theirs.<sup>11</sup>

Urban students seem more positively disposed toward formal education and they express a sense of loss at the possibility of no schools. As one might infer, this group tends to be in the academically upper classes. Upper classmen contribute to a year age difference between those who feel negatively and those who feel positively disposed toward school. The difference in freshman performance between these groups approaches statistical significance.

The third question, "Is the school giving the subject what he wants?", is concerned with the student's satisfaction with his education experiences up to the time of the interview. In general has his schooling been a happy or an unhappy experience? Although the differences are slight, those who are satisfied with their educational experience seem to be more successful in school, to have maintained their age-in-grade position better, to have come from the urban centers, and to continue with their education longer.

A fourth breakdown was, "Is education necessary for what the subject plans to do?". The separation here was on the basis of what the individual said he planned to do in the immediate as well as indefinite future. Although many individuals may have unrealistic aspirations, no judgment of reality was passed. In general the younger students are more undecided so

that proportionately, more upper classmen feel that they need a formal education to accomplish what they want to do in life. Students from the urban and state schools also feel more strongly the need for formal education to accomplish their goals, and as expected, aspire in greater numbers to those occupations which require training. More significant results might have been obtained if the interviewer had made the inquiry in a way to permit judgments on the reality of those vocational aspirations.

The final division based upon a review of the entire interview, was most subjective: Are the motivations of the individual to pursue a college education external to him or was he seeking to learn from some internally motivated sense of inquiry? The internally motivated individual sought to a greater extent, to acquire knowledge from a sense of curiosity. He regarded education as the source of enrichment of his own life and the means whereby he could become a better and more understanding person. The externally motivated individual went to the university primarily to satisfy the requirements for a vocational goal. As one might infer, the internally motivated students performed to much higher standards.

Performance in the secondary school, according to these results, is no index of motivation for an education. Neither the school system attended nor the grades achieved there can be used alone to predict potential scholarship. Too often it is only at the college that this internally motivated group learns to achieve the higher academic standards. The college academic life incorporates features which make the high school grade averages of our group, an imperfect prophecy of university success.

The most significant element leading to academic success on the basis of the questions in this study, seems to be the quality of seeking knowledge from a sense of curiosity. The closer the college student comes to relating his education to the satisfaction in living rather than a vocational goal, the greater would seem to be his chances for academic success.

Further research then, would seem to be indicated in those areas which relate to the Alaska Native's feelings toward the formal learning process as the means to arrive at established goals and attain established ideals. Since his environment does not take for granted the need for codified knowledge, a positive outlook toward the school as an institution for self-development cannot be assumed but must be developed.

Many of the Eskimo children particularly, grow and develop in a society which does not stress models. Some further understanding, then, on the formation of ego ideals would be appropriate. Who is the person

who patterns and shapes the internal development of the child?

It is a generalization perhaps, that the Alaska Native seems to have accepted the world as he found it. Living historically in a semblance of harmony with his environment, he has not traditionally explored the means to leave his mark by some iota of change or understanding which did not previously exist. Neither is his own culture dominated as is the Western society, by a drive for personal achievement, power or immortality. Some clash then, is almost unavoidable since the more developed culture brings with it aspects which are considered desirable, and morality aside, acceptance of this implies an acceptance of a Western value system or an anarchic society would be developed. One cannot accept the advantages of an urbane society without some conception and understanding of the many restraints which must be self-imposed.

A university education traditionally aims to liberate the individual from the shackles of his mortality. It cannot hope to achieve its goal with a people who do not have the intimations of immortality. The education which stresses vocational goals as its reason for being can easily become unnecessary. Technologic change and an easy dole help to ease the transition from student to drop-out. If Alaska Native people have difficulty finding employment for reasons of prejudgment, real or fancied, the development of vocational skills is again, meaningless. In a population which has no tradition of formal education, the schools might achieve greater success through the development of ways of learning and an understanding of ego-ideal formation. Early childhood exploration of the environment and natural curiosity should be encouraged and developed to greater limits. A society without a tradition of learning how to learn, cannot suddenly acquire it in six, 12 or even 20 years of formal learning. It is in this area that the schools can make a greater contribution to Alaska Native society.

#### SUMMARY:

This preliminary investigation of the motivations of Alaska Native students sought to uncover predisposing factors significant to the determination of their success, and assumed that the Native person at the university was an example of a successful person. Four major background factors were explored by the use of an open-ended questionnaire type interview: the encouragement provided by the home, the willingness of the students to attend school, the satisfaction received from the school experiences and the vocational stimulus to attend school. In addition, the interviews

were subsequently evaluated to assess whether the drive to continue in school was the result of intellectual curiosity and an understanding of the environment, or an impellant of vocational pressure. The answers to these questions were related to a number of factors including high school and university achievement. None of the problem areas were significant when related to high school achievement. High school grades could not be used to predict academic success. An understanding of education as the means to comprehend and cope with the environment - apart from vocational aspects - seemed the most significant factor in the achievement of academic success by Alaska Native students.

The assumption that Alaska Native students at the university were, ipso facto, successful because they had attained - for them - an academically exclusive status was not borne out in the course of this study. Rather it appeared that they had drifted to the university after feeling that their high school education had made them psychologically unfit for life in their village.

Very significant differences in achievement by students from the various types of high school attended, B.I.A., city and state, and mission, can be attributed to a variety of factors, which more likely reflect selective factors inherent in the student body formation, than any particular strengths or weaknesses in each type of school system.

Further research is indicated to study more thoroughly, how the Alaska Native acquires his attitudes on the nature of the learning process, how he establishes his life goals, and what should be the nature and type of ego-ideals created for him.

#### APPENDIX A: Guide for interview questions.

1. Why should people go to the university?
2. Is it desirable to leave home for an education? Why?
3. How much should one be prepared to sacrifice in order to be able to go to the university?
4. Does it make any difference whether children go to school?
5. What does schooling do for you?
6. How do parents feel about children leaving home for an education?
7. Who encouraged the Native (you) to go to school?
8. How important do the parents feel that education is for their children?
9. Who discouraged the Native (you) from going further in school?
10. What or who was the biggest help in elementary school and/or high school in preparation for the university?
11. Does the average Native person appreciate the importance of an education?
12. Why do relatively few Native people go to the university?
13. How can the university help the Native to succeed? What can the university do for you?
14. In what subject were you best? Worst? High school and college.
15. What subject was liked best? Least? High school and college.
16. What is a good university education? How? Why?
17. How does the Native (you) see himself in the future? In five years; in ten years?



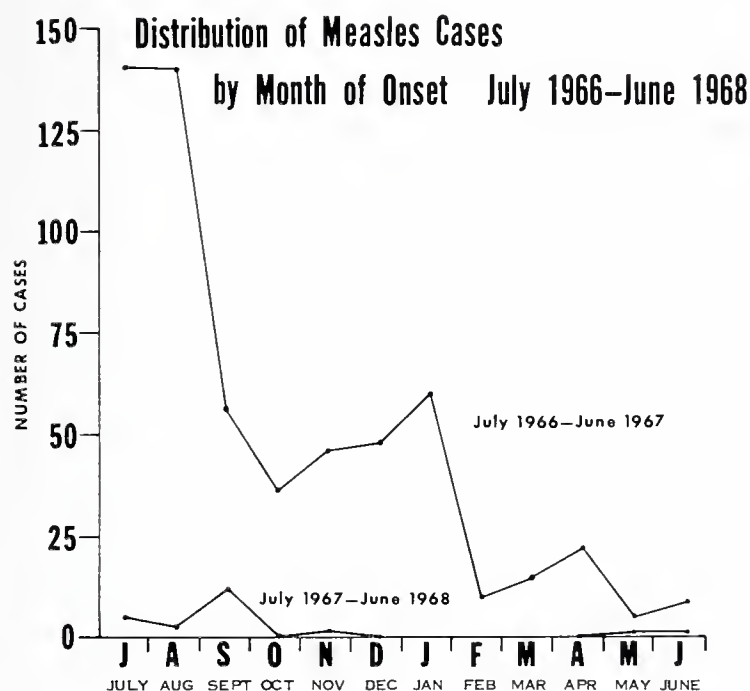
## FOOTNOTES:

1. Nulato, a fairly large village on the Yukon River with over 300 persons, for example, had its first person graduate from the eighth grade in 1951. Vide: Loyens, William J.: THE CHANGING CULTURE OF THE KOYUKON INDIANS. Ph.D. dissertation, University of Wisconsin, 1966, p.154.
2. Ray, Charles K., Joan Ryan and Seymour Parker: ALASKAN NATIVE SECONDARY SCHOOL DROPOUTS. A research report, University of Alaska, 1962, pp. 3-4.
3. Overstreet, William D.: A STUDY OF ELEMENTARY SCHOOL DROPOUTS AMONG THE NATIVE POPULATION OF ALASKA FOR THE PERIOD 1955-1962. Unpublished manuscript, Bureau of Indian Affairs, Juneau, Alaska, 1962, 71 pp.
4. These figures and the following are derived, it is hoped, with a minimum of statistical violence. In fiscal year (FY) 1966, 3140 Alaska Natives were between 20-24 and 4780 between 15-19 years of age. Using the breakdown figures of the 1960 census when 19 year olds made up 21.3 per cent of the 15-19 year group, 21.3 per cent of 4780 (1016) was assumed to be the 19 year old population in 1966. The B.I.A. survey lists 229 Alaska Native students enrolled in universities and colleges - many who are non-matriculated students - hence the 5.5 per cent figure. For the United States the data were handled similarly. Over 5.5 million persons were enrolled in higher education and 17.4 million was the total population 19-24 years of age. U.S. Bureau of the Census: STATISTICAL ABSTRACT OF THE UNITED STATES. 1967, 88th Edition, U.S. Government Printing Office, Washington, D.C., p. 133.
5. Although our sample includes more upperclassmen among the men students than the women, the high school and freshman grades are independent of present class and age. More likely the grades are a reflection of the initial performance of those students who managed to meet the academic challenge more successfully.
6. The first semester averages of all Native students in former years are predictably lower since they would include the grades of those who had fallen by the academic wayside.
7. Figures on the academic progress of Alaska Native students who entered the University of Alaska in 1964 and 1965 are from the office of the Director of the College Orientation Program for Alaskan Natives (COPAN) at the University. The statistics on the performance of all students are through the courtesy of the Director of the Counselling Office.
8. Traditionally, judgments of the actions of other persons are not considered to be in good taste. Impersonally worded queries seem to elicit, more successfully, an individual's feelings on any particular subject. To some extent, however, this precaution was less necessary in the college than it might have been in the generality of the population.
9. It may be of some interest to know that the girls, particularly, were discouraged by their peers who emphasized that college would do no good and would only prove to be an unhappy and an alienating experience.
10. The TUNDRA TIMES - the Alaska Native newspaper with the largest circulation - for November 24, 1967, points out that over a period of three years only 14 Alaska Native students have graduated from the University from 487 who entered. This last figure may be an error as other sources indicate that it should be more nearly 287 students who entered in the three year period 1964, 1965 and 1966.
11. Vide: Thompson, Hildegarde: "A survey of factors contributing to success or failure of Indian students at Northern Arizona University," in INDIAN EDUCATION. Division of Education, B.I.A., Washington, D.C., November 1, 1966, 8 pp. for a discussion of similar problems among a different group of Native people.

# ALASKA'S MEASLES ERADICATION PROGRAM

By Paul S. Clark, M.D.

*Epidemic Intelligence Service Officer, Alaska*



The combined efforts of the Department of Health and Welfare, U.S. Public Health Service Assignees and the medical profession in Alaska have brought about virtual eradication of rubeola (red measles) in Alaska.

Following the development of the live, attenuated measles vaccine, all physicians and public health personnel within the State were encouraged by the Department of Health and Welfare's Division of Public Health to administer the new vaccine to all susceptible children. Immunization clinics under the direction of the Alaska Department of Health and Welfare and the

Alaska State Medical Society were also established in most of the major cities and in outlying villages. The results of this campaign have now become apparent and Alaska will become one of the first states in the nation to be free from this disease.

Between July 1, 1966 and June 30, 1967, 599 cases of measles were reported to the Communicable Disease Section of the Division of Public Health in the Department of Health and Welfare. In sharp contrast were the 23 cases reported during the ensuing 12 month period from July 1, 1967 through June 30, 1968. The drastic results of the campaign to date together with the number of cases reported per month are depicted in this chart.

Since October 1, 1967 each reported case has been confirmed by the Division of Public Health. Viral cultures and sera have been obtained from each suspected case and are being processed by the Arctic Health Research Laboratory and the National Communicable Disease Center. A few of the Coxsackie viruses may mimic the viral exanthem of rubeola, thus it is gratifying to offer this additional diagnostic technique to the public and private physicians within the State. Our goal is the eradication of rubeola in 1968. If the attenuated vaccine is administered routinely to each infant at the end of the first year of life, it is conceivable that this goal can be obtained. A suitable motto for the coming year might well be "Morbus morbilli periat". \*

\* Report of the Committee on the Control of Infectious Diseases, 1966, American Academy of Pediatrics, Evanston, Illinois. p. 65.

# AN M. D. IN POLITICS

## HOW CAN A NICE GUY LIKE YOU WORK WITH THEM POLITICIANS?

By Milo H. Fritz, M.D.

*Representative, District Eight, Anchorage*

A politician's job can be ennobling, disillusioning, stimulating, or boring, depending upon the personality of the office-holder. For the most part I would say that the men and the one woman in the House were a dedicated, hardworking bunch. Beneath the banter, the social chitchat, the friendly insults, and the endless receptions and parties, was a hard core of responsibility that never failed to produce a promise that could be relied upon. Having to stand on one's own feet, do one's own research, make one's own mistakes, and to make and fulfill one's own bargains and agreements was very stimulating.

The money that I did not earn while serving in the Legislature in 1967 and 1968 amounted to many thousands of dollars a year according to my accountant. I considered this a noble sacrifice until I recalled that George Washington would have been hung as a traitor if caught by the British and that our early patriots put "their lives, their money, and their sacred honor" on the line for the things that they believed.

My prediction is that within five years this state will have over a five hundred million dollar budget and that the legislators will be full-time and paid about twenty-five thousand dollars a year. As it is now with no office space, no secretarial help, and an insufficient amount of funds for easy, quick, and efficient communication with one's constituents or agencies or individuals throughout the country who can supply important information quickly and accurately, we are most inefficient. I recognize also, though, that some among us do not need all the equipment and personnel of a modern business office, owing to our own particular backgrounds or the district which we represent. Some way must be found to give each access to what he needs, whether he comes from a populous area or represents the people from the bush.

The three of us representing you, Dr. Paul Haggland of Fairbanks, Dr. Michael Beirne of Anchorage, and myself, perhaps did not push through any milestones in legislation. But we were able to prevent some most unfortunate legislation from being introduced into committee, emerging from committee, or being passed on the floor. We were often called as witnesses on pending legislation that had medical aspects which a physician without political experience, however meager, could not help solve as well as one in the Legislature.

My particular interest in the Legislature can be quickly summarized. All the following resolutions and the one bill were passed and signed into law. Each title, I think, speaks for itself.

House Concurrent Resolution 32 relating to the preservation of the polar bear in Alaska will result in a study that is to be submitted to the next session of the Legislature.

House Concurrent Resolution 35 directs the administration to come up with a study relating to the establishment of physician-anesthetist teams to be transported to the rural communities of Alaska.

House Concurrent Resolution 40 directs a study to be made relating to extra courses in the formal curriculum of our high schools for those interested in following an aviation career.

House Concurrent Resolution 51 directs a study to be submitted for the next State Legislature regarding the local fabrication, fitting, and repair of spectacles.

House Concurrent Resolution 52 relates to a study concerning medical malpractice insurance, directed by the aggressive and knowledgeable Mr. W. W. Fritz, Director of the Division of Insurance. Mr. Fritz is no relative, and the loss is mine.

House Concurrent Resolution 53 directs the state to come up with a study regarding the temporary replacement of physicians on annual leave, especially from small communities. This dovetails into Public Law 89-749 and is, I hope, the final step before actual implementation of a plan that Bob Wilkins and I tried to get started as far back as 1955 when I was president of the old Alaska Territorial Medical Association, and he was its hardworking secretary.

House Concurrent Resolution 58 makes it indisputably clear that the Legislature had no intention of allowing the state to take over by eminent domain private tracts in recreation areas subsequently established by the state.

House Concurrent Resolution 60 relates to a study by the Division of Insurance concerning the frightful problem of the ever-rising rates for liability and collision in traffic accidents. Mr. W. W. Fritz has great experience in this particular field and his study, of course, should interest everyone.

House Joint Resolution 69 relates to availability for use of the United States Public Health Service hospitals and the State of Alaska health facilities for



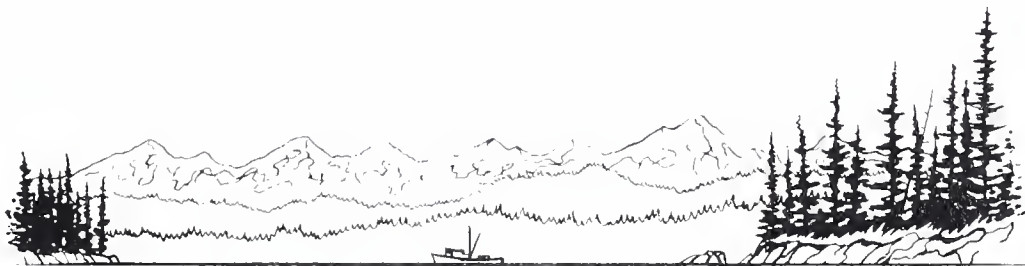
all people and by all physicians at rates exactly equal those of similar facilities, to be paid for by the patient or his insurance carrier as is the custom in non-governmental hospitals.

House Joint Resolution 75 relates to a feasibility study for a canal between the Yukon and the Kuskokwim Rivers. When this is accomplished, the vast resources along the Yukon River and its tributaries can be transported by the cheapest possible means, namely by barge, from the upper reaches of these rivers through the canal to the ocean port of Bethel. The Yukon River having a mouth unsuitable for ocean-going vessels is not an economically feasible route of water transportation.

One of the propositions coming up for your consideration in November will be bonds for increasing the ferry systems in the state. Among the items

is a million-dollar appropriation for a Yukon River ferry, which will open this fascinating and little traveled area of our state to tourists and bring a few bucks to the economically deprived people in the small villages along the way. This is "my" ferry. Eventually this will hook up with the road from Kaltag to Nome, making it possible to drive as far west as Teller, where one can actually see Russian soil.

Before closing, I should like to say that if I again run, and am re-elected, I will devote myself to the same problems enumerated, plus control of industry that pollutes the air, the water, or the land, and above all, to the construction of that canal which will raise the economic status of the people in the Bethel area from zero to something approximating the prosperity that most of the rest of us enjoy.



#### *ABORTION (Continued from page 120)*

in the hospital, even if not spelled out by law. Self-policing of the medical profession is an unpleasant chore, but in accredited hospitals it is at least done; and even if it is quite imperfect, it accomplishes ever so much more in maintaining high standards of medical practice than is attained through the surveillance of the not so watchful eyes of our public prosecutors.

While acknowledging therapeutic abortion to be a matter of medical practice and removing criminal penalties, as suggested above, would seem to be a sensible and logical solution, it is proposed by only a minority of physicians and attorneys. Most seem reluctant to overturn so completely the restrictive abortion laws inherited from our past. It is more likely, then, that any liberalized law enacted in Alaska will be along the lines proposed in the model penal code of the American Law Institute.

It is foolish to expect that reform of abortion law will bring about any substantial reduction in the number

of criminal abortions. The results in Sweden and other countries with liberal indications for therapeutic abortion show that this does not happen. American physicians will simply not accept the concept of abortion on demand, or abortion as a means of population control. Many women, therefore, will still find that no reputable physician will agree to abort them, but they will still insist on ridding themselves of an unwanted pregnancy. There is some hope, though, that more widespread knowledge and application of contraceptive methods may reduce the number of unwanted pregnancies. This, in turn, will inevitably lead to fewer criminal abortions.

Whatever form a new abortion law does take in Alaska, if it is truly liberalized it will ease heartache and conscience of both patients and physicians in those instances where therapeutic abortion is medically indicated.

# ALASKA STATE MEDICAL ASSOCIATION TWENTY-THIRD ANNUAL MEETING

Three hundred and seventy-four physicians, exhibitors, and paramedical persons attended the Twenty-Third Annual Convention of the Alaska State Medical Association June 7-10, 1968.

During the annual banquet Friday, June 9th, the physician of the year, community service, and other awards were presented. The physicians of Bassett Army Hospital in Fairbanks were honored as the physicians of the year. The inscription on the plaque presented Lt. Col. Philip W. Hardie, Commander, Bassett Army Hospital, read as follows:

"Rising like a phoenix from its own waters of destruction Bassett Army Hospital, while bandaging its own wounds, turned to mend the wounds of Fairbanks; a legacy to mankind fulfilled; a mandate for others to follow"



LTC Philip W. Hardie, Jr., commander, Bassett Army Hospital and Robert B. Wilkins, M.D., president, Alaska State Medical Association. Photo by Betzi Woodman, Anchorage.

Arndt von Hippel, M.D., Chairman of the Convention Program Committee, and Donald R. Rogers, M.D., Chairman of the Convention Arrangements Committee, were applauded for their excellent performance in planning, arranging, and presenting the convention in a most successful manner.

James A. Lundquist, M.D., the new President of the Alaska State Medical Association, presented Robert B. Wilkins, M.D., Past-President of ASMA, a plaque of appreciation for his many years of service to Alaska's medical organizations.

The scientific program and exhibit areas were well attended and the ASMA was again fortunate to have many outstanding speakers participating.

Milo Fritz, M.D. of Anchorage received the A.H. Robins 1968 Community Service Award for his years

of service to many small and large communities throughout Alaska.



Milo H. Fritz, M.D.

The Editorial Board of ALASKA MEDICINE presented Arndt von Hippel, M.D., the editor-in-chief, a plaque commending him for his time and effort in making ALASKA MEDICINE a widely read and widely admired medical journal.

Alan Homa, M.D., Anchorage, was presented a plaque from the American Medical Association for his service as an AMA physician in Vietnam.



Alan Homa, M.D., and Robert B. Wilkins, M.D., president, Alaska State Medical Association.

During the convention the ASMA adopted 34 resolutions. A resume of the important resolutions is as follows:

## LEGISLATIVE ACTIVITIES - RESOLUTIONS

A) requesting the Veterans Administration to urge



Congress to change the law to permit care of its beneficiaries in private hospitals.

B) requesting the Governor to direct the Division of Insurance, Department of Commerce, to develop a plan for making professional liability insurance available to licensed physicians at a reasonable rate.

C) urging implied consent legislation and the finding of 80 milligrams percent of alcohol in the blood to be evidence that a person is intoxicated to a degree rendering him unfit to operate a motor vehicle safely.

D) proposing a liberalization of Alaska's abortion law.

E) proposing legislation providing for broad immunity for physicians in their activities in hospital committees; conferences and courts; the giving of depositions; municipal, borough, or state committees or boards; in treating minors under emergency conditions; and in rendering medical information to school or governmental agencies.

F) requesting legislative amendments to existing laws changing the Medical Practice Act to provide that gross incompetency may be used for a basis for revocation of a license.

## MEDICAL PRACTICE - RESOLUTIONS

A) a resolution advising the Alaska Legislature and the Governor's office that in the event of depleted funds of the Department of Health and Welfare that members of the Alaska State Medical Association will continue to care for beneficiaries under these medical programs free of charge and that other vendors should also be asked to share the burden of depleted Department funds.

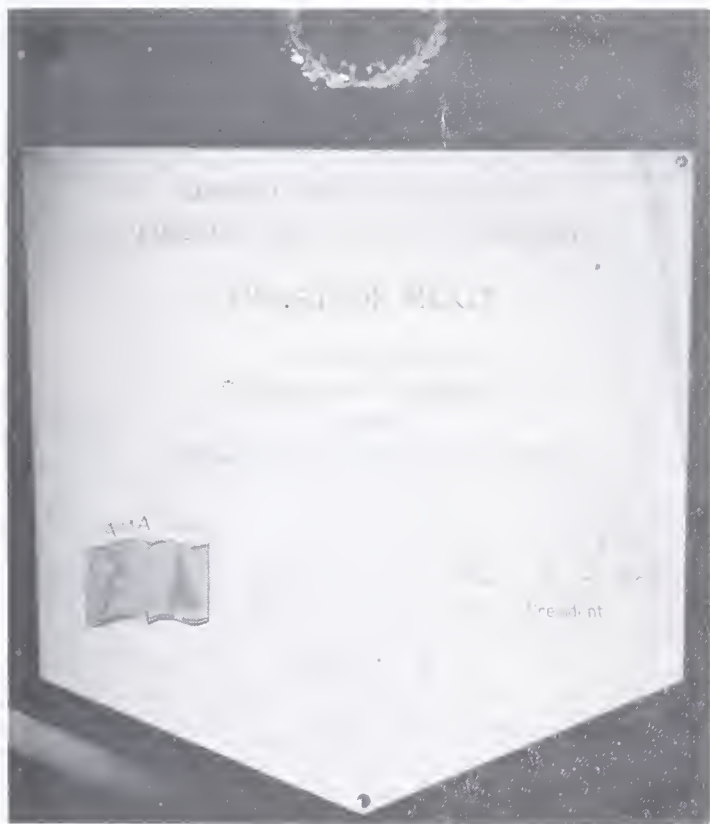
B) a resolution urging the expeditious phasing out of all federal medical programs based exclusively on ethnic considerations as rapidly as the care of native people can be assumed by private physicians and hospitals or by those state or federal programs applicable to the general population.

## OTHER RESOLUTIONS

A) requesting a waiver of Basic Science examination when locum tenens practice is requested.

B) condemning any advertising of cigarettes as showing outstanding disregard for the public health and welfare.

For copies of resolutions or information, please contact the ASMA office at 519 West 8th Avenue, Anchorage, Alaska 99501, telephone 907-277-6891.



During the American Medical Association's Annual Convention in San Francisco, June, 1968, the Woman's Auxiliary to the Alaska State Medical Association was presented an Award of Merit for its large per-member contribution to the American Medical Association's Education Research Foundation. The plaque pictured above will be displayed at the Alaska State Medical Association convention in Fairbanks June 4-7, 1969 and then will be put in the Alaska State Medical Association office for display.



Dr. John F. Lee, newly appointed by U. S. Public Health Service as Director for Alaska Native Health Area.

# CONVENTION PICTORIAL



Donald K. Freedman, Director  
Alaska State Department of Health and  
Welfare  
Public Health Division

James A. Lundquist, M.D.  
President, Alaska State Medical  
Association

Robert L. Smith, M.D.  
Assistant Surgeon General



Milford Rouse, M.D.  
Past Pres., AMA  
Speaking to ASMA  
House of Delegates



Arndt von Hippel, M.D.  
Chairman, Convention  
Program Committee

Warren Jones, M.D.  
President Elect  
Anchorage Med. Society

Rodman Wilson, M.D.  
Chairman, Legislative  
Committee and Resolu-  
tion Committee

Discuss the progress  
of the Convention



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Paul Isaak, M.D.  
Pres.-Elect, ASMA

James A. Lundquist, M.D.  
President, ASMA

Discuss the coming year



Winthrop Fish, M.D. (seated)  
Donald K. Freedman, M.D.  
A RMP Representative and  
Henry I. Akiyama, M.D.

Discuss computer read-out  
of EKG

Milford Rouse, M.D.  
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Robert B. Wilkins, M.D.  
Past Pres., ASMA

Robert L. Smith, M.D.  
Asst. Surgeon Gen.

Bill Kelly, KTVA

Discuss the changes  
in medical practice  
on statewide TV  
program





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# THE CANADIAN APPROACH TO MEDICAL LIABILITY

By Trenholm L. Fisher, M.D.

*Secretary-Treasurer,*

*Canadian Medical Protective Association, Ottawa*

A doctor cannot but feel handicapped when, to doctors in another country, he is to discuss a subject as large as medical liability. Not only is the doctor talking outside his own country but he is talking without detailed or accurate knowledge of medico-legal conditions in the other country. He can only hope that a description of the situation in his own country, in this case Canada, will have some value. As an introduction it must be made clear, even though it may be surprising, that conditions in our two countries are different and are not comparable.

One might think the difference would be slight because so many Statute laws in our two countries are almost the same; in reality the similarity between us is often more apparent than real. The differences in the manner of application of laws by our respective courts often seem to someone not a lawyer to allow, if they do not cause, great differences in the resultant decisions. If, therefore, I tell you things that to you seem illogical or that sound like non sequiturs I warn you: keep it in mind that I am talking about medico-legal things in my country, not yours.

We in Canada gather from American medical literature that in the United States the number of legal actions against doctors is increasing and that the size of awards may be increasing. Only because it has to do with our reasons for having had an actuarial survey made of our work recently is the following short explanation necessary. We are a country of 20 millions; you are a country of 200 millions. It is my guess that the number of medical journals read in Canada but published in the United States bears the same proportion to the number published in Canada, about 10 to 1 - and perhaps that ratio actually is higher. Our exposure, therefore, to what you think are the changes in your medico-legal situation is correspondingly great. Your laws and ours are closely enough alike that our Canadian profession assumes the medico-legal situations in the two countries are alike when, in fact, they are different, so different that much of the medico-legal advice from American sources is not only inapplicable in Canada, it sometimes is misleading. The Canadian profession, nevertheless, bombards its defense organization with its fears that our situation must be similarly deteriorating. So great has been the pressure on the Association that during the past year it retained a firm of actuaries to analyse its figures. The statements that I am about to make are, therefore, accurate to the best of our ability to analyse

and interpret them. The recent analysis by the actuarial consultants confirms the Association's impression: the number of legal actions against doctors in Canada is not increasing. This is the first significant fact about our situation.

Then, too, information from your medical literature has allowed unfounded fears by our profession that the size of awards to plaintiffs is increasing so much that our tiny annual membership fee may be insufficient to ensure the solvency of the Association. This, too, is incorrect and is confirmed by facts you may find it difficult to accept. The Canadian Medical Protective Association has remained solvent since 1901 and is solvent now on an annual fee which was raised reluctantly from \$15.00 to \$25.00 for 1968. The actuaries not only thought the membership fee adequate but their projection of Association activity allowed them to make the statement that they thought the fee would be adequate for the next five years and that it would allow an appropriate increase in the size of the Association reserve. The size of awards to plaintiffs in medico-legal actions in Canada is increasing no more and no faster than the value of the dollar is decreasing; in other words, the size of awards is increasing no more than enough to compensate for inflation.

Here another relevant aside must be made. The day is long past when doctors should accede to the demands by patients that something be done or that something be given whether or not the something is considered by the doctor necessary or helpful. Until relatively recently these demands could be met by placebos. Placebos, medicines given more to please than benefit, something both ineffective and harmless, have gone out of style, however. Nowadays the substitutes for placebos often are neither ineffective nor harmless; when necessary and properly used they are effective and when unnecessary and improperly used they are harmful; they often carry potentialities for harm as great as their potentialities for good. When they produce harm, they commonly produce expensive harm.

Similarly, many modern methods of treatment, of previously unimagined effectiveness, when they result in harm result in greater harm than any previous and less effective treatment would have produced. Think of the patient undergoing surgery which would have been impossible without modern anaesthetic agents and mechanisms. Think then of the anaesthetic that later it is learned was accompanied by unrecognized hypoxia



of a degree that produced permanent brain damage, that left, in rare instances, living decerebrates. That result, if it can be demonstrated to have been due to professional negligence, rather than inadvertence or uncontrollable factors, is tremendously expensive. To all the other things that would have had to be paid for previously must be added the cost of care of the decerebrate individual for the duration of what, paradoxically, is called life. The size of awards for these and similar tragedies is larger than any previously made in Canada but our Courts have not arbitrarily increased the size of awards, the awards are larger for a valid reason: the harm done is greater and correspondingly more costly.

The manner of application of our laws by courts has been consistent enough from Province to Province that one can expect the legal principles to result in similar decisions from coast to coast. This influences the Canadian medical profession's approach to malpractice actions. It can depend on decisions in one Province being accepted as precedents in another.

Now I am going to burden you with some of our basic medico-legal thinking. The doctor first. Though the onus primarily is not on the doctor to demonstrate that he did nothing wrong, the doctor's testimony must be elicited so that he does demonstrate three things. It must be made apparent in terms of the claims the doctor makes for himself, that he possessed reasonable knowledge; that he had acquired and possessed reasonable skill in the application of his knowledge; that he exercised reasonable care in the application of his knowledge and skill. It is important to give due weight to the qualifying clause, "in terms of the claims the doctor makes for himself". A different standard for general practitioners and specialists is accepted by our courts and in medico-legal actions is applied by our courts. Even though the general practitioner will be held responsible by our courts for recognizing those occasions when his knowledge is inadequate and when he should seek consultation, our courts do not demand as much of the general practitioner as of the specialist.

The onus, in our courts, is on the plaintiff to demonstrate the validity of his claim. He must demonstrate first that the doctor did owe him the duty of care; then that the doctor did not discharge this duty of care; finally that the alleged harm resulted from this breach in the duty of care. We are fortunate in Canada that our courts do not accept incomplete recovery, or incomplete restitution - anatomical or functional, or simply a poor result, as evidence of fault on the part of the doctor. Plaintiffs must demonstrate, directly or indirectly, the three things, the duty of care, the

breach of the duty and that the harm flowed directly from breach of duty.

Res ipsa loquitur - the thing speaks for itself - is seldom applied in medical malpractice actions. It is occasionally asserted in actions against doctors that res ipsa loquitur will be relied on. Not often does it prove helpful. If the doctor can demonstrate a way in which the accident happened or could happen without negligence then the plaintiff is back where he started and must prove positively that there was negligence. There is reason to think that some ramifications of the doctrine are exerting more influence in medical malpractice actions than was true a number of years ago. For example, the patient who after treatment, after surgery, is disabled by a condition that was not apparent before treatment or surgery presents in himself evidence that influences a court; if res ipsa loquitur be not applied as such there cannot help but be in the minds of reasonable people - and we think our judges are reasonable people - the inference that some explanation is necessary to refute the deduction that without fault the additional disability would not have followed. It still is true, nevertheless, generally speaking, that res ipsa loquitur is seldom applied in malpractice actions.

Neither is perfection the standard used by our courts to judge doctors. Do not be misled into thinking that our courts are tolerant of fault, they are not. If it be demonstrated that a doctor was culpably negligent our courts will penalize him with the same objectivity and impartiality that would result in his successful defense had he been without fault. The standard used by our courts to judge the doctor is that of ordinary competence - once again - in terms of the claims the doctor made for himself. This is of greater importance than it appears at first and casual thought.

It is as invariably true as anything medical can be that no doctor ever gives any patient perfect care. Even when the final result is complete recovery, it is unlikely that impartial review of a doctor's records would ever suggest his care had been perfect. Hindsight always allows someone who reviews the work to recognize places where care was incomplete, or unnecessary, or fussy, or plain wrong. Foresight, unfortunately, does not allow such certain judgment.

There is one trend we in Canada think we recognize, the tendency of the doctor whose opinion is being sought as an expert - and remember he has the opportunity to use hindsight - to point out every inadequacy in the care of the patient and to make it apparent that if there had been none of these, the result would have been different or better. It is an enlightening experience to discuss such a matter with the potential expert; to

ask him to forget the outcome and to analyse the treatment in stages, in terms of the findings available to the attending doctor at each stage; then to ask him if, with those findings, and those findings only, he could criticize the attending doctor. Time after time the answer is different.

If, on the one hand, there is evidence that the defendant doctor was guilty of professional malpractice or negligence, it is the duty of the expert to admit this and to testify to it if required. The expert should not think of himself as a partisan, rather he should think of himself as a citizen giving evidence to assist a court to reach a just decision. If, on the other hand, the deficiencies of the attending doctor are apparent only when hindsight is used and could not have been apparent otherwise, it is, equally, the expert's duty to make this abundantly clear to solicitors and to a court; to fail to do so would be just as improper as would be a refusal to recognize and testify to medical work less than competent.

In Canada few malpractice actions are tried by judge and jury. Our courts are loath to leave complex or scientific matters to a jury if their complexity makes them unlikely to be understood by the ordinary person. Not very often is a jury trial sought; if it is, the organization with which I work invariably opposes it and commonly is able to establish that the action should be heard by judge alone.

This has a number of advantages, advantages which are not unfairly helpful to the defendant or unfairly restrictive to the plaintiff. Our judges are, as they are said to be, reasonable persons, they are skilled persons; they weigh problems on the scales of reason rather than on those of sympathy.

Judgments are likely to be more penetrating and reasoned because more understanding is brought to bear by a judge than by many persons on juries. Further, juries need not, but judges must, state reasons for their judgments. These reasons can be studied. If they seem wrong, or specious, an appeal can be launched and at appeal the attempt can be made to demonstrate the flaws in the reasoning.

It should be said, too, that most people who have dealings with our courts, even when they are on the losing end, are willing to agree that our courts are realistic, that they are objective in their approach to problems, that they are as impartial as it is possible for humans to be. Even though, occasionally, all of us disagree with our courts, that disagreement is not laid to undue influence, partiality, or to any other wrong attitude.

We are fortunate in Canada that there is no animosity between the legal and the medical professions.

I think it no exaggeration to state that there is mutual respect. We doctors recognize that our legal profession is just as ethical as we think our own is. We recognize that this may be so even when our friend, the lawyer, takes an action for a client against one of us. We may wish he had not but we do not impute any wrong motives because he did.

The Canadian legal profession, too, may not do contingency fee work. Not only is this considered unethical by lawyers, as unethical as we consider fee splitting, it is forbidden by Provincial statute. We can not but think that this is an important modifying influence in our medico-legal situation.

"Nothing in sections 47 and 64 gives validity to a purchase by a solicitor of the interest or any part of the interest of his client in any action or other contentious proceeding to be brought or maintained, or gives validity to an agreement by which a solicitor retained or employed to prosecute an action or proceeding stipulates for payment only in the event of success in the action or proceeding, or where the amount to be paid to him is a percentage of the amount or value of the property recovered or preserved or otherwise determinable by such amount or value or dependent upon the result of the action or proceeding."

Because we think its existence and activities have had a significant influence on the medico-legal situation in Canada, I am going to say something about the Association with which I work. One cannot but admire the farsighted logic of the founders of the Canadian Medical Protective Association; the older one gets and the longer one observes medico-legal affairs the greater is one's admiration for the men who, when they founded the Association nearly 70 years ago, laid down principles which have proved sound. Because, in Canada, men like them can become invisible and forgotten giants of the profession, I cannot refrain from mentioning their names. The late Doctor R. W. Powell, a prominent leader of the profession in his day, conceived the idea of the Association and its principles of action. In this he was ably assisted and seconded by the late Doctor J. Fenton Argue, equally prominent in the profession of his day, who applied the principles, made them work and demonstrated their worth.

The descriptive terms they used for the Association have never been improved upon; they said the Association should be, and it has remained, a mutual medical defence union.

It is mutual in that doctors belonging to it not only provide the funds necessary for the Association's work but, when they can, they provide help freely to each



other. Doctors are members of a profession and by tradition help each other freely and without thought of reward. Our profession always has done it in medico-legal matters.

The Association, over the years, has extended the meaning of the word mutual. It has been interpreted to mean that the services of the Association shall be supplied members at cost, just enough to ensure solvency with adequate reserves.

The organization is a medical association. That has to be stressed because it is an intangible but nevertheless of fundamental importance. The Association is the profession's own, begun by, maintained by and run by the profession. Medical principles are dominant. Financial considerations are secondary. At meetings of Council discussions of claims never start by considering financial aspects; how best the doctor can be helped is the first consideration and only then is cost discussed.

As its descriptive name says, the Association is a defence organization; it exists to defend its members; it considers it a duty to defend members. It is not a financial organization to pay settlement. As in law, an accused gets the benefit of doubt, so the Association resolves doubt about a doctor's culpability by defending him.

It will be as apparent to you as to the Association that an occasional doctor will do something for which there is no defence. When this is true, the Association would be less than realistic if it did not settle rather than fight. Even here, however, the principle of defence exerts influence. Any settlement on behalf of a member must be as fair to that member as to the plaintiff. The Association, therefore, will fight an action through the courts rather than pay damages which are inflated and, therefore, unfair and unjust to the doctor.

The most important application of this principle of defence is that the Association ordinarily refuses to consider any settlement of a nuisance claim. Unless there be special reasons, the Association will seldom allow discontinuance of an action unless the plaintiff pays the doctor's costs.

It may be of value to elaborate a little on this principle and its application. A claim against a doctor often can be recognized to be of the nuisance variety. When it becomes apparent to the plaintiff that the doctor intends to defend himself, quite often the plaintiff's solicitor says, in effect, that for a small settlement the action will be dismissed or that the action will be discontinued if the doctor will assume his own costs. To both these requests the Association, acting on principle and from long habit, advises its member to say no. The doctor did no wrong and, therefore,

should make no settlement nor pay costs which the plaintiff unjustifiably forced him to incur.

There is good reason for this stand: to do otherwise is to encourage claims against doctors. News of settlements spreads more widely than most doctors realize and people in the district where settlements have been made assume they can collect money from doctors merely by threatening to sue. Similarly, if costs are waived, news spreads that it does not cost anything to threaten legal actions against doctors, that they will pay their own costs just to have the actions withdrawn. Claims in such a district increase in numbers geometrically, not arithmetically. In districts, on the other hand, where claims invariably are resisted the realization exists among people that nuisance claims get nowhere. There exists the further realization by patients that if they choose to have fun with nuisance claims against their doctors, they are going to have to pay for their fun. This is not hypothetical, theoretical, is not an abstruse bit of reasoning; it is practical and it has the advantage that it works. People get to know that to win an action a plaintiff will have to demonstrate there was malpractice or negligence.

All this allows me to summarize by saying that in Canadian experience the benefit to the profession simply cannot be estimated of having its own, primarily medical, defence organization which deals with all claims against doctors with two things in mind: that the defence of the doctor shall be the best possible for him and shall be in the manner most helpful to the profession as a whole. No organization other than a medical organization can be expected to adhere to the principle of defence irrespective of cost; can be expected to assume the greater costs and to think the money well spent to maintain a principle.

One other point I mention, in a whisper as between friends. The doctor for whom a settlement has been made, even if it be a relatively large one, has had little bother, he seems scarcely to realize he has been in trouble; there is no stimulus to review his work and improve it. But if a doctor has to spend a few days in the witness-box, has had his work criticized and his methods of work scrutinized, dissected, questioned, criticized and has had to justify himself, he knows he has been in trouble, he has had the stimulus to review his work and improve it. He is much less likely to have a relapse!

Finally, in conclusion, I will state a paradox. I beg of you to accept it: we in Canada think we have proved it. The principle of no compromise, of defending every action that is defensible is cheaper than any other method of dealing with medico-legal claims.

# MUKTUK MORSELS

## FAIRBANKS

Dr. John Fenner, formerly in practice in Fairbanks was allegedly shot and critically wounded recently in California.

Dr. R. Holmes Johnson was right and also an excellent actor! The "Cry of the Wild Ram" presented in the Kodiak open air theatre was excellent and worth the time and travel to attend. A number of Anchorage physicians and their wives made this year's performance and all were highly pleased.

## HOMER

Dr. Paul Eneboe has opened his general practice office here. Dr. Eneboe was until recently with the USPHS in Bethel. He takes the place of Dr. George Leih, who has entered a psychiatric residency.

## KENAI

Dr. Robert Stelle has left the Peninsula Medical Center and moved to Anchorage where he has joined The Doctors Clinic in general practice.

Dr. Calvin Johnson has moved his home to Kenai. He now commutes daily to his part-time Anchorage office.

Dr. Robert Struthers, who left Kenai last year after one year of medical practice, is reported to have died recently of a heart attack.

## ANCHORAGE

Drs. Helen and Robert Whaley have returned to medical practice here after a two year absence. Dr. Robert Whaley, a Board Certified Internist, is opening a private office in internal medicine. Dr. Helen Whaley, who is Board qualified now in neurology after two years at Stanford, plans to restrict her practice to neurology. Dr. Helen Whaley is also a Board Certified Pediatrician. I hope that she will now resume her previous role as originator of this Muktuk column.

Back after one year in Da Nang with the Marines, and one year as Visiting Professor of Orthopedics at Vanderbilt, is Dr. William Mills, a Board Certified orthopedic surgeon. He looks just the same; I wonder how Vanderbilt looks. Also back to his general practice after several months absence is Dr. Glen Crawford.

On the debit column of old friends is Dr. Peter J. Koeniger, who has closed his ob-gyn office here after 18 years to enter practice in Aberdeen, Washington, where he also plans to play a little golf in the rain. (Office: 400 8th Street, Hoquiam, Washington 98550) Dr. Koeniger will live only 100 miles by car from Seattle-Tacoma Airport, and plans to keep a spare bedroom open for friends from Alaska (Home: 1002 Alden Road, Aberdeen, Washington 98520)

Now in private practice here are Drs. Jean and John Chapman who recently opened offices in family practice. Before Dr. John Chapman's recent one year service as Alaska Commissioner of Health and Welfare they practiced in Cordova for five years. Dr. Jean Chapman has also had a practice in Juneau for the past year.

Dr. Donald B. Addington of Phoenix has opened Alaska's first office for the practice of plastic and reconstructive surgery. Dr. Addington is Board Qualified in Plastic Surgery.

Dr. Clyde F. Deal of Mobile has joined the Anchorage Clinic in general surgery. Dr. Deal, who left Anchorage four years ago to enter his residency, previously spent a year here in practice with Dr. Charles F. St. John. He is Board Qualified in General Surgery and replaces Dr. Edwin Kraft, who took off for his Uganda mission hospital post across the Greenland ice cap in his old Beechcraft Bonanza.

Dr. George Seuffert of New York has entered the private practice of Anesthesia in Anchorage. Dr. Seuffert was recently with the USPHS in Anchorage and is Board Qualified in Anesthesia. With his entrance into private practice the anesthesia manpower situation is finally almost adequate, and we hope to see expansion of ancillary services such as inhalation therapy.

Dr. Estol R. Belflower of Georgia has opened his office in general practice here after a period with USAF at Elmendorf.

Dr. John F. Lee, a Board Certified Surgeon, has taken over as Director of the Alaska Native Health Area. Dr. Lee, who has a Masters in Public Health Administration, replaces Dr. Holman Wherriitt who has transferred to Washington, D.C.

Dr. Carl Beck had a baby girl, Dr. Chalmers a boy, Drs. Louise and Fred Hillman adopted a baby boy, their second, Drs. Wallace and Y. O. Dunn had a girl, their fourth, and Dr. Marcell Jackson had a boy, her second.

Dr. Perry Mead married Jonnie Hyland Fox.



Dr. Alan Homay married Barbara MacKay.

Dr. Elden Maxwell married Monica Boyer.

The Tri-borough Air Resources Management District in Anchorage has been awarded \$50,716.00 by the USPHS for continuation of its efforts to develop an air pollution control program in the Greater Anchorage Area, Kenai Peninsula, and Matanuska-Susitna Boroughs.

The Anchorage Cobalt Center is rising near the Providence Hospital, and it is hoped that it will be in operation by January, 1969.

#### VALDEZ

Dr. William F. Schunk has opened an office in general practice here in addition to assuming his duties as medical director of the Harborview State Hospital.

#### SKAGWAY

Dr. Elsa Lehman has apparently closed her medical practice here.

#### JUNEAU

Dr. Kenneth Moss of Kentucky, a Board Certified Pediatrician, recently with the USPHS in Anchorage, has opened a private pediatric office here. Dr. Gary Hedges of Juneau has completed his surgical training in Ohio and plans to open his practice in general, vascular and thoracic surgery late in September. Dr. Hedges is Board Qualified in general and thoracic surgery. Dr. Joseph O. Rude is making weekly visits to Skagway where at present there is no physician.

As of July 1, the Sisters of St. Anne have leased their hospital to the Borough which is now running this hospital pending completion of the new Greater Juneau Borough Hospital.

#### SITKA

The entire situation of the Mt. Edgecumbe Hospital is rather in a turmoil at present. The Native Hospital and Native School Complex here was due for expansion when roundly criticised by a series of articles in the Anchorage Daily News. Since then these expansion funds have been frozen by the BIA. Dr. J. Ray Langdon of Anchorage recently pointed out in a letter to Dr. John F. Lee, newly appointed Alaska Native Health Area Director, that "Mt. Edgecumbe, the other large (native service) hospital, has been surplus and unnecessary certainly in that size for the last decade, and much effort has been made by its personnel to scrounge

patients from around Southeast Alaska even though they may live in Juneau or Ketchikan...to be transferred away from their homes so that the hospital at Mt. Edgecumbe can continue in operation. Again this is true at the Tanana Hospital whereby patients have to be airlifted from Fairbanks..."

It appears certain that the entire Alaska Native Health picture needs a careful re-examination. In many cases these completely segregated facilities no longer fill a health facilities gap, but rather duplicate, and compete with, existing and competent private facilities. On the other hand, there is as yet no practical alternative to the competent young physicians in the peripheral areas who are fulfilling their draft obligations by two years in the USPHS. These men make a valuable contribution and in fact, a considerable percentage of the physicians presently in private practice in Alaska originally came here for two years in the PHS. It is interesting that many of these same physicians who cared capably for the "native" while in the USPHS are now denied this opportunity when they are in private practice. Competence is obviously not then the issue.

This Federal Native Care Program is an expensive denial of integrated medical care as demanded for all other Americans by the Civil Rights Acts. Speaking to this question is Resolution 68-1 passed unanimously by the assembled members of the Alaska State Medical Association on June 8, 1968. The resolution is titled "Abolition of Federal Care to Native on Basis of Race" and reads as follows:

WHEREAS, provision of Federal Medical care to Alaska native peoples on a basis of racial origin without realistic regard to financial need is discriminatory and perpetuates dependency on the government, and

WHEREAS, there are indications of intent to expand this medical care despite the efforts of others to integrate native people into the general society of the state, and

WHEREAS, such "free" and discriminatory care often results in unnecessary duplication of medical personnel and facilities in a community, be it

RESOLVED, that the Alaska State Medical Association urge the expeditious phasing out of all Federal Medical programs based exclusively on ethnic considerations as rapidly as the care of native people can be assumed by private physicians and hospitals or by those state or federal programs applicable to the general population.

Resolution #68-2 is also relevant to this general topic. It is titled "Care of Veterans in Private Hospitals" and reads as follows:

WHEREAS, the medical care now provided Veter-

ans in Alaska is available only in federal facilities, often at a great distance from the veteran's home, and

WHEREAS, good private hospitals exist in Alaska cities, and

WHEREAS, length of hospitalization is usually shorter in a private hospital than in a government hospital, be it

RESOLVED, that the Alaska State Medical Association ask the Veterans Administration to urge Congress to change the law to permit care of its beneficiaries in private hospitals.

#### KETCHIKAN

With the addition of the crews of 250-300 seine boats to the resident population, physicians here have been working at capacity.

The new wing of the hospital is in use at present as a nursing home.

A recent cannery fire at Waterfall, Alaska near Ketchikan brought 33 patients in for emergency treatment. Dr. James Wilson gave us the following report:

"On the early morning hours of 7-13-68, the Filipino bunkhouse at the Waterfall cannery caught fire and burned to the ground. Five of the workmen died in the fire. Because the fire apparently originated in the kitchen facilities on the first floor, and the sleeping facilities were upstairs, the workmen had to escape through the upper windows, most of them jumping onto the rocky beach below.

Because of this, a considerable number had fractures of the back and of the lower extremities, more precisely, eight of the patients had compression fractures of the lumbar spine, some of them with multiple lumbar vertebra involved, and seven patients had comminuted fractures of the lower extremities. Of these, there were two patients with both calcaneus badly crushed, and several with lesser degrees of comminution of the calcaneus, one with a severe subtalar dislocation, two with very severe splintering fractures of the lower quarter of the tibia and fibula, one with vascular impairment that improved as soon as the fracture was stabilized, another patient with avulsion fracture of the tibial tubercle, who also had both calcaneus crushed. One patient had severe compound fracture of the ankle with the talus exposed for nine hours, was treated by reduction and closure and developed a wound infection. This is the only immediate complication of this group of injuries.

In addition to these serious injuries, several

puncture wounds of the bottom of the foot, several patients with a concussion injury and interestingly enough, only three or four patients with first and second degree burns and one patient with fairly minimal third degree burns of the arms were seen. Only one of the burn patients ended up requiring grafting. One patient did have a fractured head of the radius, but this was the only upper extremity fracture.

Transportation of these patients to the hospital was achieved through the cooperation of the local airlines; Alaska Airlines, Simpson Airlines and the helicopter evacuation for the United States Coast Guard at Annette Island. The local ambulance services were alerted and the hospital was put on the previously rehearsed emergency plan.

The night staff and afternoon staff of nurses were brought in to supplement the personnel and all of the physicians were put on standby and then utilized as patient load necessitated. We were able to make use of the Alaska Native Service unit in the hospital for the ambulatory injured after they had been sorted out and the two Public Health physicians, Doctor Ronald Tinsley and Doctor Gregory Ladas helped considerably in the management of this less severely injured group.

The success of this operation hinged on the excellent cooperation of the medical staff, the paramedical and nursing staffs, and all the other people who helped in the face of this emergency."

#### WRANGELL

We hear that federal funds have been granted to assist in the completion of a new 12 bed hospital here.

#### PORTLAND

Morningside Hospital has apparently closed recently. It will be recalled that Alaskan patients were withdrawn last year to Alaskan facilities after many years of using Morningside for chronic in-patient hospital care.

#### MIAMI BEACH

The AMA 22nd Annual Clinical Convention is planned here December 1-4, 1968. The scientific program will appear in the October 21 JAMA.



# POLLUTION

by Clifford P. Judkins, R.S.  
*Environmental Health Director,  
CAAB Health Department*

During the past 100 years, pollution has spread from the sluggish Mississippi to the mighty Yukon, from Lake Erie to Campbell Lake, and from the air of New York and Los Angeles to Fairbanks and Anchorage; and it continues to spread and threaten our actual existence on this planet. This article will confine itself to water pollution problems within the Greater Anchorage Area Borough.

Human sewage waste disposal practices within the Borough include the use of privies, chemical toilets, cesspools, septic tanks, holding tanks, collector lines, raw sewage outfalls, one aerated lagoon and one small treatment plant. The treatment plant serves one trailer court and is owned and operated by a private firm. The aerated lagoon serves one subdivision and is also owned and operated by a private firm. Together these two treatment facilities serve less than 400 dwelling units. Excluding the 400 homes served by the two treatment facilities, all of the sewage produced within the Greater Anchorage Area Borough (some 14 million gallons per day) is either discharged into the ground or into Cook Inlet. Fort Richardson, Elmendorf Air Force Base, the City of Anchorage, the Greater Anchorage Area Borough, the State of Alaska, and Central Alaska Utilities (the local private utility) all use salt water outfalls to discharge untreated human wastes into Cook Inlet.

Approximately 7 million gallons of raw sewage is discharged into the Inlet every day. While the practice of collecting the sewage through collector systems and dumping it into the Inlet removes the sewage from people's backyards and prevents water supply, stream and lake contamination, the hazard is just transferred from one location to another. The location of existing outfalls are such that the sewage is quite often swept back to the beach by tides and currents. Recognizable human fecal matter can be found on the beaches from the Port of Anchorage to Earthquake Park on almost any occasion. Quite often the reply to this comment is, "So what." The modes of transmission of infectious diseases are many. The dogs and cats that frequent the beaches carry fecal organisms home on their feet; children playing on the floor contaminate their hands and of course, their hands wind up in their mouths. The seagulls that wallow in the sewage while they eat it for lunch can commonly be found resting in the Ship Creek reservoir--our drinking water.

Many communities have fallen into the "easy way out" trap of collecting but not treating sewage. The raw sewage is discharged to a large lake, bay, river

or inlet where it appears to be bothering nothing; but the communities expand and grow--more and more sewage is discharged. The degradation of these large bodies of water takes place slowly with consistent determination. The people continue to proclaim that it is impossible to pollute all that water, but it happens little by little, day by day until corrective action is either impossible or too costly. Such great rivers as the Potomac and the Mississippi have been converted from clear, fish-filled streams to sluggish, open sewers that reek from decaying filth. Lake Erie and San Francisco Bay have likewise been abused and destroyed. The history of these cases is repeated time and time again and yet the public remains apathetic and continues to assure itself that it cannot happen here--it can and it will.

The millions of gallons of sewage from our sewers and those of other towns, the tons of silt from construction and gravel operations along our creeks, the oil spills, the platform garbage, wastes from ships,--all of these things are dumped in the inlet daily. Of course, the inlet is large. It can dilute, or assimilate, large quantities of waste, but as the "flour is added, the gravy thickens" and sooner or later the inlet will follow Lake Erie to destruction. The balance of the sewage produced in the Greater Anchorage Area Borough (approximately 7 million gallons per day) is discharged into the ground through the use of cesspools or septic tank-seepage system arrangements. Since the beginning of Anchorage, the cesspool has been the common method of on-site sewage disposal. Cesspools are pits in the ground lined with logs or other material. Raw sewage is discharged into these pits via a sewer line from the house. The raw, untreated sewage then seeps off into the ground. The effect is cumulative--some of the sewage is filtered out fairly well; some is not. The ground around the cesspool becomes saturated, polluted. As time goes on, the polluted area grows. Eventually, it overlaps with the one next door and so on until entire subdivisions are literally floating on sewage. The sewage makes its way to the surface and seeps into streams, lakes, and wells.

The septic tank-seepage system arrangement commonly used in this area consists of a septic tank and a log crib pit. The sewage from the house is discharged into the septic tank where it undergoes sedimentation and anerobic bacterial digestion. This process removes about 90% of the solid material and 30-40% of the bacterial load. It does not sterilize the sewage and does not remove all pathogenic organisms.

The effluent from the septic tank is discharged into the pit from where it seeps off into the ground with the same effects as the cesspool. The benefit of the septic tank is that the soil is more capable of handling the partially treated septic tank effluent; consequently, soil saturation and pollution does not occur as rapidly.

The chaotic, haphazard development occurring in the Anchorage area perpetuates the spread of pollution. Allowing the subdivision of land for the purpose of building homes in areas of tight soil and high water table and where public sewers are not available and allowing subdivision of land into small lots (less than 20,000 square feet) is most probably the prime cause of surface water, ground water, lake and stream pollution.

A report written by the U. S. Department of Health, Education and Welfare, Water Supply and Pollution Control Program, Pacific Northwest Region IX, entitled, "Water Well Contamination and Waste Disposal in the Greater Anchorage Area," (August, 1965), makes the following statements:

"The Greater Anchorage Area has a dual problem associated with the contamination of private water wells and haphazard arrangements for sewage disposal.

The contamination of these wells (private wells) is undoubtedly related to waste disposal practices in the area." (See map)

"The widespread development of the area has resulted in the following methods of sewage disposal:

1. Some of the areas are served by sewer systems which discharge untreated sewage to tidal waters. This practice results in the depositing of organic materials on the tidal flats.

2. Some of the inland developments have sewer systems with sewage treatment facilities. Each plant has a holding pond for ground absorption of the plant effluent. This practice usually results in the effluent entering shallow water sands or in a build-up of the water table to the point that seepage to the creek occurs.

3. Septic tanks, seepage pits, and cesspools are used on an individual basis in some of the residential areas. This practice can result in the discharge of untreated or partially treated sewage to shallow water sands, usually in close proximity to individual water wells.

Reportedly, the creeks and many small lakes in the area have recreational usage by children and adults. It is understood there is sport fishing, including salmon fishing, in Campbell Lake and Creek. The discharge of treated or untreated sewage to these small creeks and lakes would materially degrade their recreational value. The development of a sewer system in the

lower Campbell Creek area was initiated by a private utility company to alleviate existing inadequate sewerage facilities and to maintain the recreational values of this area.

The development of a centralized sewer system with adequate treatment to serve the entire area would effectively:

1. Reduce pollution of individual wells.
2. Maintain acceptable water quality conditions for recreational use of creeks and lakes.
3. Reduce the possibility of disease transmission to children and others using the creek and tidal flats.
4. Eliminate other public health nuisances associated with the haphazard disposal of sewage.
5. Permit the orderly development of the Greater Anchorage area."

The Greater Anchorage Area Borough Health Department is continually confronted with sewage disposal problems involving illegal practices or malfunctioning systems. During the spring of each year large numbers of on-site sewage systems fail, forcing sewage to the surface of the ground and threatening public health. Many entire subdivisions are confronted with this problem.

In other areas the soil will not handle the sewage during any period of the year leaving the property owner with no alternative other than to have the system pumped out on a weekly or, in some cases, daily basis. Pumping on a regular basis is costly and many property owners eventually resort to some illegal practice such as pumping the sewage to a ditch or piping it to a creek.

The Greater Anchorage Area Borough adopted a new sewage disposal ordinance on July 1, 1968. This ordinance will adequately handle existing and new developments in areas where soil conditions are adequate as it establishes minimum design standards which will give longevity to on-site sewage disposal systems. The ordinance also provides an effective tool to prevent new construction where soil conditions are not adequate. The ordinance does not adequately cope with existing problem areas as it provides only the legal tools to enjoin or cite individuals whose sewage facilities do not function properly; it does not provide a solution to their problem.

The only permanent solution to this dilemma is to provide sewers to existing problem areas and prohibit development of new areas where soil conditions are not suitable unless sewers are provided.

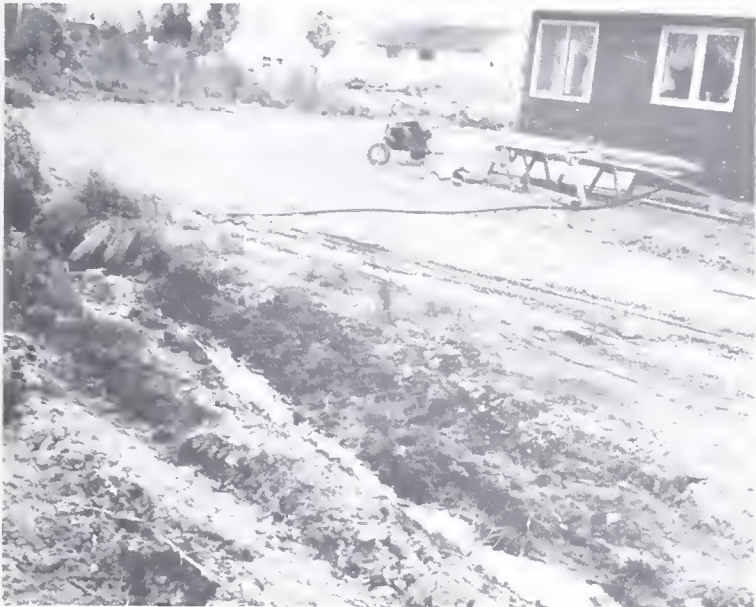
If we could just put aside the petty bickering, personal animosities, and jealousies, that have for three years prevented the sewer program from moving ahead, we could get the job done and effectively curtail



the continuing degradation of the environment of our community.

If our community is to survive the developments of the next 20 years, we must all work together towards the common goal of logical, environmental planning and development.

The state, the borough, the cities, the boards and commissions, private enterprises, and the "man on the street", must all become aware that our environment, (the water, the air, and the land), does not have an unlimited capacity to handle our wastes. Our environment is our most valuable resource--it is why we are here. The environment of other communities, of other states, has been degraded to the point of becoming undesirable for human habitation through the same process that we are continuing to perpetuate here today.



Example of illegal practices resorted to by home owner. The cesspool serving this home failed. The home owner had installed a large hose to discharge household wastes into a back yard ditch.



Human wastes discharged into open pit. Public restroom facilities are located 10 feet from the end of the pipe.



An example of the health problems confronting many Anchorage area residents each spring. The back yard and the basement of this home flooded with human wastes.



In this picture a child is playing near broken sewer manhole on the beach near Elderberry Park.



Broken sewer manhole on beach near Bootlegger's Cove. The broken manhole discharges raw sewage above low tide and accessible to pets, children, animals, etc. Point Woronzof, the Borough's planned outfall site, can be seen in the background.





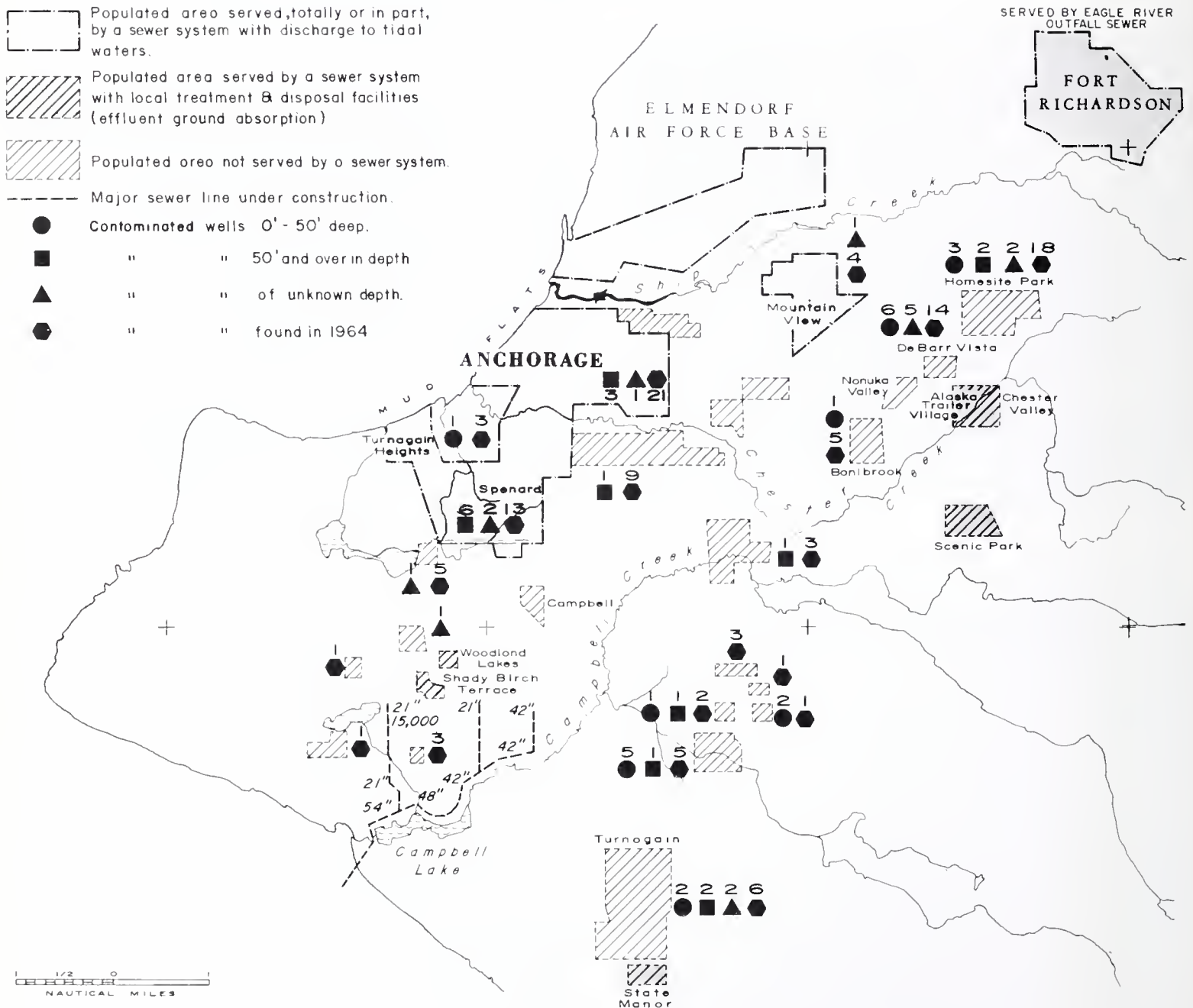
Children crossing ditch full of raw sewage on their way home from school.



Cesspool overflow pipe discharging into Campbell Creek. Many people try to eliminate their sewage disposal problems in this manner.

LEGEND

- Populated area served, totally or in part, by a sewer system with discharge to tidal waters.
- Populated area served by a sewer system with local treatment & disposal facilities (effluent ground absorption)
- Populated area not served by a sewer system.
- Major sewer line under construction.
- Contaminated wells 0' - 50' deep.
- " " 50' and over in depth
- " " of unknown depth.
- " " found in 1964



WASTE DISPOSAL RELATED TO  
WATER WELL CONTAMINATION



# SALMONELLA ANATUM:

## REPORT OF AN ALASKAN OUTBREAK

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Each year, in Central Alaska, the incidence of gastroenteritis increases with the arrival of warm weather, reaches a peak immediately prior to the arrival of cold weather and then falls to a low level during the winter. The disease symptoms may include nausea, vomiting, abdominal discomfort, diarrhea and headache. Fever is absent in most cases. The infection is usually irritating rather than debilitating and normally persists for 24 to 72 hours. In the majority of the patients, a causative agent is not found and in such cases, the disease is assumed to be viral in nature. It is also known, however, that *Salmonella* and *Shigella* infections are more prevalent during these periods.

During the epidemic in the autumn of 1964, in one 24 hour period 35 students at the University of Alaska reported to the Health Center complaining of gastroenteritis. Although symptoms were mild in most of the students, four were acutely ill with temperatures ranging from 103° to 104.6° F. All four were hospitalized.

Rectal swabs were taken immediately upon admission. A preliminary examination of the culture plates revealed colonies resembling enteric pathogens. A slide agglutination test with *Salmonella* polyvalent somatic antisera was strongly positive.

As soon as these preliminary reports were received, the school physicians requested an epidemiologic investigation. The investigation was conducted by the Alaska Department of Health and Welfare, assisted by the United States Air Force Arctic Aeromedical Laboratory.

### Investigation Procedure

The initial investigation began with the four hospitalized students. It was noted that all became ill a few hours after eating a supper served in the University cafeteria on the preceding evening. In addition, the patients stated that several fellow students had become ill with similar but less acute symptoms during

this period. A review of the Health Center records showed that 40 students had reported with symptoms of gastroenteritis between lunch on the preceding day and the time when the investigation began. However, only the four hospitalized students had displayed elevated temperatures and acute symptoms.

All students who had reported to the Health Center were requested to return for re-examination. Some were still experiencing minor symptoms while the rest were asymptomatic. A detailed history of activities and diet was elicited and a rectal swab was obtained in each case.

Affected students who had not reported to the Health Center were traced and asked to report for examination. Each was interviewed and fecal specimens were obtained.

In addition, new cases were interviewed and material collected for culture.

Lastly, food samples and surface swabs were obtained from the cafeteria and snack bar; food-handlers were asked to report for interviews and fecal culture. Although food samples from the attack day were not available, items from the same lot were taken from storage. Particular attention was paid to those items of food usually associated with outbreaks of this type.

### Results and Conclusions

Three hundred individuals were cultured during the outbreak of gastroenteritis. This group included approximately 215 students, all of whom experienced symptoms to a greater or lesser degree, 84 part-time or full-time food-handlers who were asymptomatic, and one part-time food-handler, a student, who developed minor clinical manifestations.

*Salmonella anatum* was isolated from 43 members of the group. The 43 patients included 35 students, four full-time food-handlers, and four part-time food-handlers, all of whom were students. Cultures from the

food samples and surface swabs were negative for enteric pathogens.

Since positive cultures were obtained from 17 of the first 30 students and two of the first 22 handlers, it was believed initially that the outbreak would be an extensive one. However, only six of the next 42 individuals had positive cultures and the remaining 18 isolates occurred sporadically among more than 200 individuals.

Assuming that patients became infected during the 24 hour period prior to the onset of clinical manifestations, it is likely that 19 of the symptomatic patients were infected on the original attack day. 16 became infected during the next week and one was not discovered until eight weeks later. Information on the last patient indicates that he became infected at an earlier stage but did not report the symptoms at that time. Since seven of the eight food-handlers were asymptomatic, it was impossible to estimate when they became infected.

As a result of their findings, the investigators concluded that the outbreak was initiated by food-handlers. This conclusion is based on the following observations: (1) Samples from the food lots and surface swabs from the cafeteria were all negative for Salmonella. (2) A cook and a line-server were discovered to be asymptomatic carriers of Salmonella anatum. Their contact with food and utensils provided an obvious means for dissemination of the infection. (3) The low attack rate suggests that dissemination was sporadic, as from one or more food-handlers, rather than widespread, as would be expected with contaminated food or equipment. Over 500 individuals were served at each meal during the attack day(s) but no more than 40 reported symptoms and no more than 19 were actually found to be infected during any 24 hour period.

Lastly, in the opinion of the investigators, many of the patients were victims of a viral illness rather than a Salmonella infection.

Therapy

Antibiotics were administered to 41 of the 43 infected patients. One of the two remaining individuals left the area before treatment was commenced and the second patient underwent surgery and could not be evaluated.

The 41 patients may be divided into two groups. 37 individuals were treated by the school physicians. Four patients, all full-time food-handlers, received therapy from a private physician.

Antibiotics used by the Health Center physicians

included Tetracycline, Neomycin, Chloramphenicol, Paromomycin and Ampicillin\*; all drugs were administered via the oral route. The daily dosage and duration of therapy with each drug was as follows: Tetracycline, one gram for five to seven days; Chloramphenicol, two grams for five to seven days; Neomycin, two grams for 10 days; Paromomycin, two grams for five days; and Ampicillin, six grams for 21 days.

18 of the 37 patients had positive stools at the conclusion of therapy and, therefore, received a second course of antibiotic therapy. Of those 18, nine remained positive and thus required further treatment; eight of these nine patients were cured bacteriologically while one was lost to followup. Thus, 64 courses of therapy were required in 37 patients. The results obtained with each drug are summarized in Table I. Clinical remission was achieved in all but one patient three to seven days after the initiation of therapy.

Table 1  
Results of Therapy

Antibiotics	No. of Treated	No. of Successes	No. of Failures
Tetracycline	30	12	18
Chloramphenicol	3	1	2
Neomycin	6	1	5
Paromomycin	3	3	0
Ampicillin	19	17	1(1)*
Unknown	3	2	1
Total	64	36	28

\* One patient was lost to followup.

Each of the four full-time food-handlers treated by a private physician received two or more antibiotics simultaneously. Three patients were given a single course of therapy comprising Neomycin, two grams daily for five days, Tetracycline, one gram daily for seven days, and Ampicillin, one gram daily for seven days. The remaining patient received Chloramphenicol, one gram daily for two days and Tetracycline, one gram daily for two days followed by Neomycin, two grams daily for five days and Ampicillin, one gram daily for seven days.

In all four cases, negative cultures were obtained one week after the initiation of therapy and at follow-up three weeks later.

Sensitivity Patterns of Salmonella Anatum

Tables II and III summarize disc-sensitivity or tube-dilution (M.I.C.'s) studies from four patients, each of whom required three courses of therapy to achieve bacterial eradication. The results indicate

\* Supplied by Bristol Laboratories without charge.



Table II.  
In Vitro Disc/Agar Results of Four Patients

Agent	Disc Conc	Patient No. 1 Culture No.			Patient No. 2 Culture No.			Patient No. 3 Culture No.			Patient No. 4 Culture No.		
		1	2	3	1	2	3	1	2	3	1	2	3
Chloromycetin	30 Mcg	S	S	S	S	S	S	S	S	S	S	S	S
Tetracycline	30 Mcg	S	R	R	R	R	R	S	R	R	S	R	R
Neomycin	30 Mcg	S	R	R	S	S	S	S	S	R	S	R	R

a changing pattern of sensitivity of the organisms to the antibiotics and suggest that in these cases, increasing bacterial resistance was a significant factor in the poor initial responses to treatment.

Side Effects of Therapy

Six of the 19 patients treated with Ampicillin developed urticarial reactions which appeared after 5, 8, 10, 17, 20 and 21 days of treatment respectively. In each case, therapy was discontinued as soon as the urticaria was noted. Fortunately, all six patients responded readily to treatment, even in those cases where therapy was abbreviated.

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DR. ROUSE (Continued from page 110)

a particular condition in a person and send him back to live in a disease-ridden environment.

Curing the health problems of the slum is a matter of curing the slum itself; of destroying the causes and eliminating the symptoms of what we now recognize as the slum life.

This country has never faced a more important task with respect to a segment of its own people. None has ever been deserving of more dedicated, more co-operative effort.

Table III.  
In Vitro Results by Tube Dilution Method (Mcg/ml)

Agent	Patient No. 1 Culture No.			Patient No. 2 Culture No.			Patient No. 3 Culture No.			Patient No. 4 Culture No.		
	1	2	3	1	2	3	1	2	3	1	2	3
Paromomycin	6.25	6.25	12.5	6.25	6.25	12.5	12.5	12.5	12.5	12.5	12.5	12.5
Polycillin	-	7.5	15	7.5	15	30	15	15	15	15	15	15

Discussion

This outbreak in Fairbanks, Alaska was only one of 52 reported in the United States during 1964.<sup>4</sup> It was not totally unexpected since over 20 species of Salmonella, Shigella and related pathogenic bacteria had been recovered in the area during the preceding 18 months.<sup>2</sup> Although most of the organisms were derived from non-human sources, their presence indicated the existence of a constant, potential hazard.

Since the outbreak a close surveillance of enteric infections in the Fairbanks area has been maintained. Although several species of Salmonella have been recovered from humans and non-humans during this period, Salmonella anatum has not been isolated.

ACKNOWLEDGEMENTS

The authors gratefully acknowledge the assistance of the entire team of technicians, nurses and other personnel who assisted in this outbreak. A special note of recognition is paid to SSgt. Charles E. Busbee, USAF, and Mrs. Susan Carter, R.N., for their long hours and valuable assistance.

Let us assure this nation that the medical profession is doing and will do everything it possibly can; but that it cannot solve the problem alone. Because the problem is not one of health alone.

I have great faith in the people of our nation -- a truly American Society characterized by successful accomplishments through private enterprise and personal initiative and integrity. Therefore, we invite all citizens to participate with us in the tonic of a great and challenging task. On to successful progress and ultimate victory!

## BOOK REVIEWS

### "MANUAL ON ALCOHOLISM"

American Medical Association - 1967

This Manual is concise, current and helpful. Presented in four brief sections (The Problem, The Causes, Alcohol: Its Metabolism and Pharmacology, and Diagnosis and Treatment), it covers the range of questions rising in the mind of the practitioner facing an alcoholic. For example, "Is alcoholism really an illness?" is handled legally (courts recognize it as a "disease"), as a manifestation of underlying psycho-pathology, as a complication of other conditions, and as a symptom which eventually becomes an illness. Here it is logically classified as a complex illness.

The definition: "Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity; by progression; and by tendency to relapse. It is typically associated with physical disability and impaired emotional, occupational, and/or social adjustments as a direct consequence of persistent and excessive use." The extent of the problem is estimated at 4-6 million in the U.S. Regardless of the actual incidence and prevalence "when viewed in terms of the tragedy, unhappiness, misery, suffering, and indeed the waste of life which the illness brings to its victims and their families, even the most callous observer must be impressed." Perhaps the most significant topic is the treatability of the alcoholic since so many physicians have experienced a "hopelessness" in dealing with these patients. It is pointed out, however, that the physician generally has the first opportunity to identify a person's alcoholism, to initiate a treatment program, and to utilize the assistance of other professionals in rehabilitation.

This 87 page booklet devotes the first half to diagnosis and treatment. The appendix is valuable because of the "clues" given to aid in the diagnosis of alcoholism (i.e., surreptitious drinking or gulping of drinks, tendency toward making alibis and weak excuses for drinking, persistent, vague, somatic complaints without apparent cause, particularly those of insomnia, gastrointestinal difficulties, headaches, anorexia). The appendix also includes management of the hospitalized alcoholic.

Considering the extensive medical literature as well as books, pamphlets and printed advice for the layman, this manual is masterfully concise and readable. With word economy the reader is presented with significant factors in the causation of alcoholism

(physiological, psychological, and sociological) in a dozen pages.

For the physician doubting his ability to treat patients with illnesses having strong emotional components, as with alcoholics, and for those with a concern over saying or doing the wrong thing, the author states this is frequently based on the mistaken belief that successful treatment demands thorough knowledge and mastery of psychiatric principles and techniques. There is simply no substitute for interest in the patient as a person, concern over his welfare, and earnest desire to help him in ways that are necessary, all of which are quickly perceived and usually responded to favorably. "Do's and Don'ts" are suggested by such italicized statements as: "Bold confrontation can be expected to destroy rapport promptly," and excessive "understanding" intended to make a pleasant relationship nullifies effectiveness, "the patient's word should be accepted whenever possible," "physicians should make clinical, not moral, judgments," and "success and failure in reaching the alcoholic patient should not be taken at face value."

This booklet is valuable to the physician who may treat only one alcoholic per year, since a ten minute scanning will provide twelve months of nourishment.

Donald K. Freedman, M.D.

### DIAGNOSTIC PROCEDURES IN GASTROENTEROLOGY

By Charles H. Brown, M.D.

438 pp., illustrated

St. Louis: C. V. Mosby Company, 1967

\$19.75

Physicians interested in gastroenterology, whether from a medical or a surgical point of view, have long felt the need for a manual of diagnostic procedures, as the use of an obscure test often has meant a time-consuming search through the literature. The Head of the Department of Gastroenterology at the Cleveland Clinic, Dr. Charles H. Brown, has filled this void admirably in his text Diagnostic Procedures in Gastroenterology, which is based on the mimeographed manual which has been used for several years in the training program at the Cleveland Clinic.

Starting with brief and excellent discussions of the role of diagnostic procedures, history, physical examination, and roentgenographic studies, the book proceeds to discuss systematically each of the many tests used



for each part of the gastrointestinal tract. The authors have not attempted to present definitive discussion of any one test, but rather have given us concise outlines for the purpose of orientation, with emphasis on the indications and contraindications of each test, its value, technique, and the interpretation of results. Selected references are added for each. Over 50 procedures are included, ranging from the most common (such as proctoscopy) to recently introduced ones (such as pancreatic scanning with selenomethionine), the ultimate value of which is perhaps yet to be determined. There are chapters on the diagnosis of

intestinal hemorrhage, and a section on the specialized treatment of hemorrhage, peptic ulcer, and obstruction. A supplement adds a collection of instructions to patients with special problems (ileostomy, constipation, etc.), and another supplement is a collection of special diets.

The result is a very useful manual which should find its place in the library of every hospital and clinic, and of every physician who uses gastroenterologic techniques.

Frederick J. Hillman, M.D.

## CLASSIFIED AD SECTION

This classified ad section is provided to give members an opportunity to make known their needs for medical and paramedical personnel. Please address all correspondence regarding insertions to: Robert G. Ogden, Executive Secretary, Alaska State Medical Association, 519 W. 8th Avenue, Anchorage, Alaska 99501.

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# NOTICES

## PSYCHIATRIC SEMINAR PLANNED IN ANCHORAGE OCTOBER 11 AND 12

1. The Sponsoring Agencies: The University of Utah, Department of Psychiatry, Division of Continuing Education and the Alaska Psychiatric Institute plus the Alaska State Medical Association.

2. Place: Friday the seminar will take place at the Alaska Psychiatric Institute, and Saturday the program will be held in a convention room in the Anchorage Westward Hotel. All Anchorage physicians will be invited to attend either or both of these programs. The Friday program will start at 9:00 A.M., with lecture-type presentations of material about the major tranquilizers and anti-depressants. Then those attending this particular seminar will break up into small groups where informal discussions will take place and where various types of patients and drug problems are presented to the small groups of physicians. The visiting faculty, and hopefully some of the Anchorage psychiatrists will act as group leaders for the small groups.

On Saturday morning, October 12, at the Anchorage Westward Hotel a more formal meeting will be held. The subject material for this particular meeting will be: use and abuse of minor tranquilizers, suicide and depression, some aspects of obesity and the importance of sleep in the emotionally disturbed patient. This meeting will start at 9:00 A.M. and end around noon.

3. Faculty: The visiting faculty will consist of Burtrum C. Schiele, M.D., Professor of Psychiatry, University of Minnesota Medical School; Eugene L. Bliss, M.D., Professor of Psychiatry, University of Utah Medical School; Arthur C. Traub, Ph.D., Director of the Division of Psychology, University of Utah Medical School; and Herbert B. Fowler, M.D., Director of Continuing Education in Psychiatry, University of Utah Medical School. In addition it is hoped that several of the local psychiatrists in the Anchorage area will help with the program material, especially acting as small group leaders on Friday.

4. There will be no admission charge and we will apply for AAGP credit.

5. Following the Anchorage seminar the visiting faculty will break up into small teams and will travel to Fairbanks, Tanana, Sitka, Juneau and Ketchikan where they will meet on an informal basis with any interested physicians -- discussing any topics mentioned in item 2, or other material the physicians might request.

Now starting:

Grand Rounds in Psychiatry at API in the second floor classroom, each Wednesday beginning September 18, 1968 from 3:30 to 5:30 p.m. All members of the Alaska State Medical Association are invited.

An announcement of the particular program for the week can be obtained by calling Dr. Carl D. Koutsky's secretary, Mrs. Mary More at 277-6551, Extension 211.

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Applications are now being accepted for the group entering in July or September, 1969. For information, write to Helen M. Wallace, M.D., School of Public Health, University of California, Berkeley, California 94720.





# ALASKA Medicine

Volume 10, Number 4    December 1968

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# Plane Crashes—Flips—Pilot Breaks Leg

anks, July 18. Pilot Jerry Fallon, en Road, escaped serious injury to- he plane crashed during -

his wheels caught in a recently plowed furrow. The plane flipped completely over, trapping the pilot. "he con'

Issue, a. tember th fications" ton dicta Although made Mor. down by a ter sharp flat obje was passe Board 1 McCredir tion" st elimin the st. The a ment cal. limit rat mile li "cut-off public dren priv be b or th schoo. The so so rather burse

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**Warnings:** Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia.

In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.

**Precautions:** In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.

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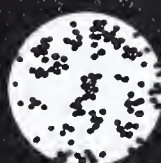
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**Contraindications:** This product is contraindicated in those individuals who have shown hypersensitivity to any of its components. Do not use in the external ear canal if the eardrum is perforated.

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# ALASKA MEDICINE



*Official Journal of the Alaska State Medical Association  
Official Journal of the Alaska Dental Society*

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*Cover photograph of Juneau, Alaska taken Christmas Day 1966  
by John F. Bowler, X-ray technologist, Central Peninsula Clinic.*

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# RUSSELL C. SMITH, M.D.

## 1903-1968



*Russell C. Smith, M.D.*

Russell C. Smith, M.D. of Petersburg, Alaska died unexpectedly this August in Seattle of a cardiovascular ailment following abdominal surgery at the Virginia Mason Clinic. At the time of his death, Dr. Smith was taking his first vacation since arriving in Petersburg in 1951.

Dr. Smith received his Medical degree from the

University of Wisconsin Medical School in Madison in 1929. He interned at Iowa State University and entered graduate training at Barnes Hospital, Washington University, St. Louis, Missouri.

The passing of Dr. Russell C. Smith leaves a void in the hearts of Petersburg residents who for the past 17 years have learned to love and honor "their" Doctor. They knew him to be a most human and understanding man whose every waking moment was consumed with his work. Long hours were the rule and not the exception for Dr. Smith. He was the confidant and "father confessor" of all who knew him. An Episcopalian, a Mason, and a Shriner, Dr. Smith had a wide circle of memberships and interests, from sponsoring a bowling team to memberships in Medical groups. He was a trustee of the Virginian Mason Research Center, a member of the Industrial Medical Association, an Officer of the Alaska Health Association, and a member of the Alaska State Medical Association.

Dr. Smith anonymously sponsored a \$200.00 scholarship each year for a graduating High School Senior who was selected by school officials.

There are many stories of Dr. Smith's generosity and thoughtfulness. The community of Petersburg is saddened by the loss of a great humanitarian.

## ONE SOLITARY LIFE

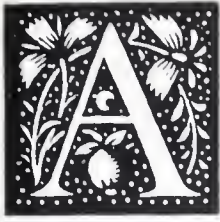
*Author Unknown*

*Submitted by Paul C. O'Connor, S.J.,  
Providence Hospital, Anchorage*

*He was born in an obscure village, the child of a peasant woman.  
He grew up in still another village, where he worked in a carpenter shop until he was thirty . . . .  
Then for three years he was an itinerant preacher.  
He never wrote a book.  
He never held an office.  
He never had a family or owned a house.  
He didn't go to college.  
He never visited a big city.  
He never traveled two hundred miles from the place where he was born.  
He did none of the things one usually associates with greatness.  
He had no credentials but himself.  
He was only thirty-three when the tide of public opinion turned against him.*

*His friends ran away.  
He was turned over to his enemies and went through the mockery of a trial.  
He was nailed to a cross between two thieves.  
While he was dying, his executioners gambled for his clothing, the only property he had on earth.  
When he was dead, he was laid in a borrowed grave through the pity of a friend.  
Nineteen centuries have come and gone, and today he is the central figure of the human race and the leader of mankind's progress.  
All the armies that ever marched, all the navies that ever sailed, all the parliaments that ever sat, all the kings that ever reigned, put together, have not affected the life of man on this earth as much as that ONE SOLITARY LIFE.*





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Anchorage, Alaska



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**By James A. Lundquist, M.D.**

It is obvious that, in spite of its being phased out everywhere else, the USPHS is expanding in Alaska. It is empire building, while making a last ditch stand. It is obvious, too, that, as the need decreases, the services of USPHS in Alaska increase, and further, that these expanded services of the USPHS then cut deeper into the private practice of medicine. By such expansion, for example, the USPHS discourages the development of private medical services in areas such as Tanana, Bethel, and Kotzebue.

Above all, the USPHS is a 100% socially discriminatory effort on the part of the United States government! Why don't we have an Alaska Negro Health Service, too? Or any other? This is, in a sense, reverse discrimination.

For long periods of time the ANHS in some cities (Fairbanks was notable) gave the ANHS recipients a relatively free choice of physicians. During the past five months these people have had a completely free choice, in that they could select for their care any physician in the Tanana Valley Group or in the Fairbanks Clinic. This widening of choice was suggested and approved by me at a time when our group had an exclusive contract with ANHS on a fee basis.

Now because of generally increasing hospital and "medical" costs, the ANHS is again restricting the choice of its beneficiaries and shunting its patients to a military hospital (which many of them do not like, and many military physicians resent).

A recent letter from ANHS to all Fairbanks "contract" physicians included the following instructions:

"1. Beginning on November 1 all new prenatal cases presenting and requesting authorization for care will be scheduled to Bassett Army Hospital for their prenatal

care, delivery and postpartum care. A patient desiring to deliver at Tanana (USPHS) Hospital rather than at Bassett Army Hospital should make such a request when requesting authorization for care. Obstetrical cases already under care by private physicians prior to November 1 will continue their care with their present physician through their postpartum checkup. New obstetrical cases under care for other conditions will be authorized for care at Bassett Army Hospital unless the Service Unit Director of the Tanana Hospital requests other arrangements.

2. Any patient in the care of contract physicians that is found to need the service of a specialist, not represented in that particular group of practitioners will be referred back to the PHS Health Center to have such services arranged for at Bassett Army Hospital or from other sources. Direct referrals from contract physicians for these services cannot be authorized without contacting the PHS Health Center.

3. Contract physicians are reminded that when a Native beneficiary patient is found to need extensive or expensive workup the PHS Health Center or the Service Unit Director of the Tanana Hospital should be contacted for the most efficient and economical way to accomplish same and conserve CMC funds. Such workups can be accomplished at Tanana, Anchorage or at Bassett Army Hospital.

4. Contract physicians are also reminded that when in the course of a patient's continuing care it becomes obvious that a long standing or chronic condition exists or may exist requiring frequent continuing follow-up visits, the Service Unit Director should be contacted concerning such a case and its needs. The needs may be better met by an extended period of hospitalization for complete workup or prolonged treatment in a PHS facility or Bassett Army Hospital. This approach might make for better patient care in the long run.

5. Emergency trauma cases should be directed to Bassett Army Hospital at the onset whenever possible. It is of course realized that occasional emergency trauma cases will arrive at the Fairbanks General Hospital and the nature of their condition not permit

transfer to Bassett Army Hospital at that time. However, when the patient is stabilized and his condition permits, he should be transferred to Bassett Army Hospital.

6. The Tanana (USPHS) and Anchorage (USPHS) hospitals will continue to be utilized to the maximum extent possible as determined by the Tanana Service Unit Director.

7. In any case where there may be questions concerning disposition or any case in which circum-

stances might influence disposition or treatment of same, the Tanana Service Unit Director should be contacted."

I think that the role of the USPHS in Alaska is worth discussing at length.

As pointed out elsewhere in this issue of Alaska Medicine, our primary concern is with government encroachment on the patients' and the physicians' individual freedom and not with financial gain.



*"The Great Alone" by Fred Machetanz.*

Collection of Mr. and Mrs. Ed. Suddock, 26 by 32 oil painting on masonite.

This painting depicts the insignificance of man against nature, especially in Alaska with its backdrop of mountain and snow in contrast to a small single figure, perhaps a hunter, trapper or prospector. The massing of darks and lights as pattern and composition is evident in this painting.



# COMPREHENSIVE HEALTH PLANNING FOR ALASKA

## ITS MEANING AT STATE AND LOCAL LEVELS

By Donald L. Freedman, M.D.

*Director, Division of Public Health,  
Alaska Department of Health and Welfare*

*Presented at the Annual Meeting of the  
Alaska State Medical Association,  
June 7, 1968, Anchorage*

I believe Comprehensive Health Planning will become a great thing for Alaska - given time! In substantiation of this belief, my talk will cover 3 topics related to CHP:

- I. Its significance to Alaska
- II. Its dynamic nature
- III. The role of physicians

The term "health" in this context will be used in its broadest sense. It includes all health services provided by professionals and by paramedical personnel; services of public as well as private institutions; preventive, diagnostic, curative, social and rehabilitative services; and such health-connected factors as education, transportation, safety, sanitation, purity of water and air, and industrial health.

Frequently I've heard it said that we've "done planning" before and what has it accomplished? We still have problems - problems of: health manpower, transportation for medical care, dental care, a dual system of health care, malnutrition and many others.

True - many have devoted time to studying, thinking and planning for pieces of health care, for finding the "nuts and bolts" to do patch work. But to me, it's comparable to a high school social science teacher saying to her prize pupil, "Go home tonight and prepare for me a 10,000 word essay on 'The Future of Man', describing his origins, present status and relationship to the universe."

By contrast, Comprehensive Health Planning today states: go home with this budget, get some staff and an advisory committee, including technical committees, and experts, and gradually determine whether we are getting the most out of our health dollars. If we are not, study where and how we are wasting funds and how to try to utilize them more effectively.

AND ONE MORE THING - "You now have responsibility and authority! Use it!!"

That is what we are talking about today. Tax dollars and private dollars that speak for more efficiency in every facet of health -- from the training of health professionals and sub-professionals and non-professionals to:

1. spacing of children

2. spacing of cobalt units and hospitals
3. ensuring that health department budgets are oriented toward the whole person rather than to a piece of him

4. preventing measles instead of treating measles encephalitis

5. permitting the physician to use his time and skills in medicine instead of clerical or social work activities

6. establishing priorities in the expenditure of funds where they are most needed and where the pay-off is greatest.

What does this mean to Alaska? An opportunity:

To figure out how to integrate all health and medical services for greatest effectiveness.

To try new ways of getting "expert" care (not necessarily medical) to all villages.

To consolidate significant health information on an individual, or family basis, throughout the years of health care.

Perhaps to have all significant health information about a patient, no matter what its source, or when it occurred, available to the physician at the push of a button.

To seek ideas of the practicing physician as to how public funds may be utilized to assist him in preventing illness, in diagnosing, treating, and rehabilitating individuals and families.

To involve lay persons as well as health specialists in arguing, explaining, learning, and in overall planning - in putting together the thousand pieces of the jig-saw puzzle which is, plain and simply, comprehensive health services for each family.

Of course this is a gross over-simplification. To determine whether it is wiser to spend a dollar on: measles immunization; or family planning; or sewage systems; or nursing homes; or adequate diets for children and expectant mothers, is not a simple matter!

And even if this were to be accomplished, what would be a sensible distribution of funds today would

not be tomorrow. The emphasis must change as the needs or the priorities change. This resiliency has not been possible in the past because of rigid, categorical funding limited to specified diseases such as V.D. and Tuberculosis. Such an irrational approach to planning for health has actually speeded the arrival of the Comprehensive Health Planning concept.

The most positive statement that can be made about CHP is that the State of Alaska (and regional health planning groups) is free to plan its own healthy destiny, under CHP. In this process of evolving agreements on the most desirable distribution of funds, year by year; of coordinating Federal, State and locally funded programs; of utilizing Blue Cross, private health insurance, Medicare and Medicaid; of minimizing duplication; and of eradicating a double standard of care, it is certain that tempers will flare, heads will be "bashed", compromise will be essential, studies will be undertaken - and still, each decision will be arrived at, not with the precision of scientific accuracy, but with a consensus founded upon a broad base of opinion, broader than ever in the past.

A moment ago I noted five examples of problems, such as health manpower and dental care, out of a possible one or two hundred - each one of which is complex to the nth degree - complicated by such factors as:

- 1. Amount of local funds appropriated.
- 2. Amount of State funds appropriated.
- 3. Amount of Federal funds appropriated.
- 4. Results of reliable studies on morbidity and mortality, resulting from diseases and injuries.

- 5. Opinions and feelings of members of the CHP Council.
- 6. Expressions of governing bodies, professional organizations and voluntary agencies.
- 7. Availability of qualified persons to fill staff positions.
- 8. Availability of physicians to commence practice in outlying communities.

My thoughts on CHP are best summed up in tabular fashion and are listed below.

No master CHP Plan exists at the moment. No rigid guidelines exist. No single method of developing a CHP exists. What we evolve here, therefore, will be of our own doing, of our own talent and convictions. We should not start out with any misunderstanding; never will there be sufficient funds for all services, personnel, structures, equipment and studies that may be indicated. Inevitably, therefore, choices must be made. And it is the function of CHP to become skillful enough to make the wisest and most productive choices.

As I contemplate the responsibility that has been given to the CHP Council, it reminds me of the universality of difficulties faced in all areas of the world, as stated by Kimble, writing of tropical Africa:

"It is bad enough that a man should be ignorant, for this cuts him off from the commerce of other men's minds. It is perhaps worse that a man should be poor, for this condemns him to a life of stint and scheming, in which there is no time for dreams and no respite from weariness. But what surely is worst is that a man should be unwell, for this prevents his doing anything about either his poverty or his ignorance."

COMPREHENSIVE HEALTH PLANNING

<i>Its Significance to Alaska</i>	<i>Its Dynamic Nature</i>	<i>Role of Physicians</i>
1	2	3
a. Offers a voice to and involvement of thousands of persons in considering their own health needs and interests, through Regional Comprehensive Health Planning groups.	There is a vast, continually changing set of health problems and needs (personal health; environmental, such as air and water pollution and radiation; industrial; health structures) also Tbc., otitis media, enteritis, accidents and other major causes of ill health and morbidity.	Advise in his areas of knowledge, i.e.: programs for prevention of cancer, heart disease, middle ear infection and prematurity, early detection programs for high risk groups, prenatal care, vision maintenance.
b. Makes it possible to coordinate the myriad health and related services, i.e.: rehabilitation, social services, home health services, curative, preventive.	Continuing assessment and evaluation of health production and costs.	Official statements and resolutions of the ASMA Council and of local medical groups.
c. Enables us to make more effective use of funds for health care and progress.	Budget, too, is dynamic. Budget varies - never adequate to supply all needs. Who will determine priorities as to hospital care, dental care, prenatal, education for sensible health habits, early care for mental illness and mental retardation?	Participation on State and local health planning bodies.



# CONTINUING EDUCATION IN MEDICINE

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I had planned to stress continuing education in psychiatry and for psychiatrists in my remarks. As I thought more about the matter, I felt I probably should emphasize instead continuing medical education -- which is of course the context to which continuing education in psychiatry belongs. As a result, I found myself preparing my presentation for today with emphasis on continuing education in medicine, a topic which lends itself readily to the theme, "the future of medical practice" and which has been much in the foreground recently in discussions and conferences on medical education: at meetings of the Association of American Medical Colleges, the American Medical Association, and of such national medical organizations as the American College of Physicians and the American Psychiatric Association; in conferences at the federal level in the Department of Health, Education and Welfare, including the U. S. Public Health Service, the National Institutes of Health, and the National Institute of Mental Health. And as you know, the Regional Medical Programs were charged specifically in the legislation creating them with organizing and carrying out continuing education.

But enough of this introduction. Let me get on with a description of the field and with critical comments and suggestions on how to implement continuing education. There has been a welcome and needed spate of reports and articles in the recent medical literature declaring the importance of continuing education for all physicians after they have completed their graduate education (as interns, residents and fellows) and have been qualified and are in practice. Lifetime Learning for Physicians, the title given by Dryer to the 1962 report of the Joint Study Committee on Continuing Medical Education,<sup>1</sup> further emphasizes its significance. The Coggeshall report in 1965, Planning for Medical Progress through Education,<sup>2</sup> points out the need to view medical education as a continuum, and stresses how the explosive growth of knowledge and the new technology tend to render the practitioner's skills obsolete and his understanding inadequate. In short, the physician today is not at any time a finished product and must accept continuous education and re-education. That society needs protection from those practitioners who neglect their continued education as well as from

those whose basic competence is inadequate has been made clear in growing criticism nationally by the public through the communications media. The report of the Citizens Commission on Graduate Medical Education in 1966, known as the Millis Commission,<sup>3</sup> underscored the need for continuing education and added the possibility of repeated examination for the updating of medical licenses.

The objectives and basic principles of programs of continuing medical education are contained in a pamphlet first prepared by the Council on Medical Education of the AMA in 1957 and last revised in 1967.<sup>4</sup> The ultimate aim is improved health care of the patient made achievable through participation of each physician in suitable programs of continuing education, in addition to his own experience and reading. All such programs should strengthen the habits of critical inquiry and balanced judgment that are the mark of the professional man. The effectiveness of the programs should be measured by building in the opportunity to actively evaluate how closely the program comes to achieving stated objectives, such as changes in the attitude and approach of the learner to the solution of medical problems; correction of outdated knowledge; explication of new knowledge; introduction to and mastery of specific skills and techniques; and alteration in the habits of the learner.

The universities, medical schools, professional associations, industry, voluntary agencies, and state and federal governments have increased their commitment to continuing education in attempts to cope with the ever increasing supply of new knowledge. As pointed out by EDUCOM<sup>5</sup> it seems that such activities may be built more upon a sense of urgency to do something than upon any generally shared body of information about what is needed and what can be done with a target population of practitioners. The model used seems to be designed for academic instruction rather than continued learning; and the education is more episodic than continuing. The availability of particular communication methods seems to mold the decision rather than clear definitions of purpose. It appears that each profession and each institution pursues an independent course and rarely examines others' experiences, or shares, collaborates, or communicates

their successes and their failures. EDUCOM<sup>5</sup> proposes a study of continuing education (but not until the summer of 1969) which will attempt to look at the whole area of lifetime learning for professionals in order to develop a body of knowledge unique to learning by adults. If continuing education is regarded as a process of learning there should be a common set of principles and procedures that would be helpful when applied to the content of any professional discipline. The study will explore the educational issues which beset all professions rather than the content problems. It is pointed out<sup>5</sup> that if sufficiently strong motivation could be provided for the professional to continue his education, more practitioners in all fields would try to stay abreast of new developments. It has been suggested that if each professional could take a self-administered test which would involve the use of the computer, his own shortcomings would be pointed out to him and his motivation to continue to study would be strengthened. (This has actually been done by the American College of Physicians in its Medical Knowledge Self-Assessment Test.) Analysis of the computerized data would enable determination of the kind of information needed by the average practitioner; thus some studies have indicated that it is not the new knowledge, but rather a loss of the basic knowledge he learned in his professional training, that distinguishes the out-of-date practitioner from the newly graduated professional.

The article entitled "Continuing Education for What?"<sup>6</sup> by George Miller of the University of Illinois College of Medicine is provocative in tone. Miller is critical of the fact that most programs of continuing medical education have been conducted by the traditional methods of teaching rather than being based on solid evidence about the way adults learn. The categorical content model has been used (e.g., cardiology, gastroenterology, hematology, etc.) and not the process model. Miller criticizes (and I agree with him) the overemphasis on practitioners needing more information and their clamor for better means of dealing with the flood of information to the point that educational programmers grasp at any straw and offer currently such straws as: programmed instruction, 8mm. single-concept films, television--both one- and two-way, either live or taped. These are held out as potent mechanisms for meeting the educational need. The programmer is very pleased when the practitioner recalls the sampled information, especially if he reports he has enjoyed both the dose and the vehicle. Miller is led by what he considers inescapable evidence of failures, to conclude that we have been educating for the wrong thing. As he puts it, the question is not the absolute worth of new knowledge but of relative priorities in continuing education. Attention should be

given to those things likely to be of great import in the care of many rather than to those things which will benefit only a few. He cites the repeated and disheartening examples of the failure of education built upon the content model to alter substantially the behavior of practitioners. Practitioners who learn more about topics do not necessarily transform this knowledge into action. He cites an instance where at a conference on "Engineering Systems for Education and Training", it was stated that while the education technology industry knows a great deal about the science and technology of information processing and transmission, it knows very little about the human receiver of that information.

Miller<sup>6</sup> is, I feel, constructive in his recommendation that we try the process model rather than the categorical content one. He points out that there is ample evidence that adult learning is not most efficiently achieved through systematic subject instruction. It is accomplished by involving learners in identifying problems and seeking ways to solve them. It comes in a growing need to know, not in categorical bundles. It ultimately incorporates knowledge in a context that has meaning. Knowledge and performance are overlapping qualities but not identical dimensions. While the best performance is built upon sound information, the provision or even acquisition of sound information is not assurance that it will occur. The obvious fact is that men learn what they want to learn. The first step is not to tell them what they need to know; it is to help them to want what they require. It means involving participants in identifying their own educational needs, in selecting the learning experiences most likely to help them to meet the needs and in assessing whether they have learned what was intended, not merely in determining whether they took part in the learning experience or even whether they liked it. If the final evidence demonstrates clearly that the desired learning did not occur, then another look must be taken at both the objective and the instructional method to determine which requires change.

The most important element of continuing education may be in leading practitioners to a study of what they do, to an identification of their own educational deficits, to the establishment of realistic priorities for their own educational programs. One way used, as part of the Utah Pilot Study,<sup>7,8</sup> was to ask individual physicians to record the clinical problems they encountered over a 48 hour period, as well as to record a personal perception of their educational needs. This approach will be used in a pilot study of Illinois psychiatrists.<sup>12</sup> Once health needs of a target population have been determined, an inventory of the resources (information, professional skills, diagnostic and thera-



peutic tools) available to meet them can be developed.

In his sketch of a process model<sup>6</sup> Miller points out that the research interests of teachers are unlikely to be the most useful program determinants in the continuing education of practitioners, because the interface between the known and the unknown is ever changing and this is rarely the point at which the most profitable educational investment can be made. Practitioners need to be involved in an analysis of the extent to which they use themselves and the available resources to meet identified needs. The documentation of discrepancies between optimal and actual performance is merely the beginning of an educational process with the greatest likelihood of success: one which is built upon demonstrated and acknowledged need.

"The practitioner-learner must progress steadily from listener to questioner to contributor. To help this accomplishment, the academician-teacher must change in the opposite direction until at last he becomes a thoughtful listener to those who are trying desperately to tell him some of the things they need if they are to be more successful in their work instead of remaining a gifted dispenser of things they might use to become more like him."

I agree that continuing education should mean continuing self-education, not continuing instruction. To directors of programs of continuing medical education it should be pointed out that they are not unlike the practitioners who are the objects of this effort. Until they recognize a need to know it is unlikely that they will learn. Miller ironically ends his article by quoting Pogo: "We have met the enemy and they are us."

There is a moot question about content-oriented educators being successful in process-oriented continuing education programs without some retreading of the older ones and some training of new leaders in the science of education. There are opportunities for those committed to an educational career in medicine to gain these special skills. For example, the Center for the Study of Medical Education (at the University of Illinois College of Medicine) offers (1) one- to two-year fellowships in educational research and development, or (2) jointly with the College of Education, a graduate program leading to a Master of Education (in medicine) degree; (3) a more abbreviated six-week introduction to educational science which is being developed specifically for individuals directing programs of continuing education; and (4) with the support of the National Institutes of Health's Division of Regional Medical Programs, a series of one-week programs is being planned to orient educational practitioners in medicine to some of the content of

educational science in such specific fields as instructional systems and evaluation.

An important consideration is by whom and where are continuing education courses in medicine conducted?

The AMA in its annual report on Medical Education in the United States has included a section on continuing education courses. In the report for 1967-68<sup>9</sup> academic year, 1830 courses were reported to the Council on Medical Education -- an increase of 14% over 1966-67. Courses are listed for 40 states and District of Columbia. No courses were reported for 10 states. (Alaska, Delaware, Hawaii, Idaho, Montana, Nevada, New Hampshire, New Mexico, North Dakota and West Virginia.)\*

An accreditation program for institutions offering courses in continuing medical education was instituted in June, 1967 when the Council on Medical Education formally accredited 14 institutions,<sup>8</sup> of which 12 were undergraduate or graduate medical schools. This year (1968) nine more institutions (23 in all) were added to the list, six of them medical schools.

A healthy and forward looking plan which might help forestall mandatory recertification and relicensure is the relatively successful 1967-68 Medical Knowledge Self-Assessment Program of the American College of Physicians<sup>11</sup> and the American Psychiatric Association's plan for a Psychiatric Knowledge Self-Assessment Program for 1968-69.<sup>12</sup>

Another promising development, if implemented successfully, is the suggestion that there be set up a medical care facility to be primarily used for continuing education of physicians (or a series of them) to be called a National Graduate Medical Center.<sup>13</sup>

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# PREDISPOSITIONS TO SUCCESS BY ALASKA NATIVE STUDENTS

## AN INTERIM STUDY

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This interim survey sought to uncover some of the predisposing factors related to the achievement of success by Alaska Native people. In most of the significant areas of the American way of life; living standards, health standards, academic achievement, for example, the Alaska Native is far below the mean of the United States population. The "worst slums in the United States..."<sup>1</sup> are in western Alaska. The Native population survives on a mixture of use-subsistence economy supplemented by a few jobs but principally by relief checks.<sup>2</sup> Although much positive progress has been made since the Parran Report<sup>3</sup> in 1955 revolutionized the approach to the health problems of the Alaska Native, his health standards are still among the worst in the country; the infant mortality rates among the highest.<sup>4</sup> As Margaret Lantis recently stated, the Native Alaskan culture no longer exists: what we see is primarily a poverty culture in the Alaskan environment.

Formal education is a relatively recent experience for the native Alaskan. In many outlying areas of northern and western Alaska, particularly, the completion of the eighth grade is a very recent event.<sup>5</sup> Most recent statistics indicate that the adult population averages between six and seven years of schooling<sup>6</sup> and that only a little more than half the population who entered the first grade in 1954 completed elementary school at the end of eight years.<sup>7</sup> Only about 5.5 per cent of the eligible Alaska Native population is enrolled at a college or university. Comparable figures for the United States indicate about 32 per cent are enrolled in institutions of higher learning.<sup>8</sup>

In an earlier study<sup>9</sup> made in 1967, 37 Alaska Native students at the University of Alaska were interviewed. This preliminary study assumed that a person who had finished high school and enrolled in college was successful. The Alaska Native student at college had achieved more than 95 per cent of his fellows; he was also conveniently accessible for purposes of inquiry. This assumption proved untenable. The Alaska Natives at the university were not successful in the usual meaning of that word. There were too many students who were able merely to remain longer in school and drift on to the university. The Native

freshman grade averages were slightly lower than the general population of the university and the group who had survived the first semester at college did not average a "C" grade for that period. This preliminary investigation suggested areas which seemed to be significant in relation to success at the University; the home background, students' ideas on the purpose of a university education and what he hoped education would accomplish for him.

This second study, therefore, undertook to follow up in the areas thought to be significant. The background of the parents, the feelings of the students themselves on education, their education, their home environment, their future and their goals - the areas suggested by the earlier study - were examined in a more detailed and somewhat less subjective manner than before. In order to help identify the student at risk who would need special guidance and counseling services, students were separated by differences in their background to see how they performed as entering freshmen. It was assumed, of course, that native intelligence and ability were not the significant factors in the achievement or non-achievement of these students.

Success, again, was arbitrarily defined to be an achievement far beyond the average of the Native population in an area of value to Western society. Academic success was presumed to have some relationship to success in general. The measurement of success in business or almost any other area of endeavor would entail problems of definition and value and would also have been too subjective. The verbal fluency of the Alaska Native students at college also made the collection of data easier than it might have been for any other group.

### METHOD

Forty-one Alaska Native students at the University of Alaska were interviewed in February, 1968. An open-ended questionnaire was employed with questions designed to circumvent the usual tendency for Alaska Natives to express opinions they think the examiner wishes to hear. (Appendix A)



The 1967 inquiry had been subjectively and *post facto* evaluated; the questions applied were derived after the interviews. In order to permit broader statistical generalizations the earlier questions were now applied to both groups. Although the 1968 judgments are less subjective for reasons inherent in the newer questionnaire, there was still some basis for comparison.

The information was collected on two sheets of paper with only an identifying number on the interview record. The first sheet held the vital data such as name, age, home, school attended and school records, etc. The second sheet contained only the interview record.

THE SAMPLE

The 1968 group interviewed consisted of 41 persons; 25 women and 16 men who, on a scale in which A = 4 and D = 1, averaged 1.898 as freshmen. Ten of these persons had also been interviewed in 1967. Ethnic self-identification, however, is voluntary; it can be misleading in the sense that an Alaska Native can remain unidentified at the University if he should so choose. These 41 persons interviewed, however, were considered to be a representative sample of the Alaska Natives in attendance at the University. The records of the 27 additional students who were interviewed only in 1967 were available. This provided a total of 68 persons from whom statistical generalizations could be drawn. Seventeen students of these 27, however, were no longer enrolled at the University of Alaska. Although the reasons for non-enrollment were not necessarily academic, some comparisons could be made with those who remained.

None of the seniors interviewed either year were women although they are more numerous than men in the freshman and sophomore years. In tabular form the distribution for the combined as well as the 1968 group is as follows:

	1968			1967-68		
	<u>total</u>	<u>male</u>	<u>female</u>	<u>total</u>	<u>male</u>	<u>female</u>
Freshmen	23	6	17	37	12	25
Sophomore	8	2	6	15	6	9
Junior	5	3	2	10	6	4
Senior	5	5	--	6	6	--
Total	41	16	25	68	30	38

Consistent with the higher grade placement the men are two and one-half years older than the women (19.88 vs 22.375 years) and unlike the traditional impressions the men here are significantly<sup>10</sup> better

students (grade averages 2.13 vs 1.77). This difference may reflect the greater number of male upperclassmen among those interviewed and is the freshman average of a group destined for an academically longer life. Perhaps there are some significant differences in attitude toward education between the Alaska Native men and the women for whom equality is not a part of the cultural tradition.

Because increasing numbers of students are now coming from the public high schools - as opposed to the BIA high schools - as in Bethel and Nome, freshman performance by Public Health Service Unit area was evaluated. The seven Service Units of Alaska are each moderately homogenous except, perhaps, for Anchorage. People from these areas do seem to possess some unique characteristics. Although the difference between extremes was almost a third of a grade (e.g. Kotzebue vs Anchorage) statistical analysis indicated that the students were nevertheless of the same population; the differences were not significant.

Earlier research indicated that the high school grades of our population could not be used to predict college performance. This is still true; there is still only an insignificant correlation ( $r = .37$ ) between high school and freshman performance. An evaluation of grades by the type of high school attended - BIA, Mission, and public school - for a comparison of the relative predictive value of their graduates - showed that there was a significant difference ( $p < .05$ ) between students from the BIA high schools and from the public schools. For our group at least, the public high school grades come closer to predicting freshman performance than either the Mission or the BIA high school grades.

RESULTS AND DISCUSSIONS

1. FAMILY ATTITUDES TOWARD EDUCATION

The home environment is normally considered to have a critical effect in the development of individual attitudes. Innumerable dropout studies have pointed to parental indifference to schooling as a significant element to the development of similar attitudes in children. In Alaska, as Ray pointed out for the larger Kuskokwim-Yukon area<sup>11</sup> there are few economic developments in the village which would utilize the school-learned skills beyond the third grade level. The home has already had the opportunity to discourage the potential collegian long before he finished high school. Nevertheless, this facet of the students' development was examined. Although we deal with what the students say is their parents' attitude, the results can still be meaningful.

Parents' attitude seems to have little direct effect upon the groups interviewed. There were no significant differences in performance between students who felt parental encouragement and those who did not. Many claimed that, for their parents, they represented income lost to the family. Over half the group interviewed felt that their parents had either opposed attendance at the University or they were unenthusiastic. Despite these neutral or negative feelings many parents still recognize that tertiary education is an opportunity for a better job, to be a better person and, in many cases, a chance to break out of the poverty cycle.

Although less than two-thirds (26) of the students interviewed learned English as a first language, the slight difference in the freshman performance in their favor (1.99 vs 1.72) is not statistically meaningful. Students' impressions of what their parents think about education and their first language do not appear to be significant factors in the students' initial performance at the University.

The relationship between parents' education and children's performance was examined for the 62 students for whom figures were available. Where neither parent had achieved an eighth grade education only two students averaged better than a "C" for the first semester. Where both parents combined had less than 12 years of education only three persons did "C" grade work or better. Low educational achievement of parents, therefore, would seem to place a student at risk although the converse does not apply. The correlation between educational achievement of parents and student performance overall is negligible ( $r = .306$ ).

The educational attainment of parents of the upperclassmen interviewed was then compared with parent achievement of the freshmen interviewed who were not enrolled in 1968. The parents of the upperclassmen were very significantly better educated (15.75 vs 10.0 years of school,  $p < .01$ ).

Although overt family attitudes seem to bear little relationship to freshman performance, the educational achievement of the parents does seem to have some bearing on the students' performance as a freshman and to his longevity as a student.

## 2. STUDENTS' ATTITUDES TOWARD EDUCATION

The inquiry into attitudes was to examine any relationship between the way a student sees education reorganizing his own life and the way he performs as a student. Hypothetically at least, if the student wants something with great intensity attainable only through an education, the motivation to perform well should be great.

Most students as we shall see, seem to regard the

enhanced job opportunities as the primary value of a university education. Higher education is, of course, hardly necessary for survival as an Alaska Native in the village. Too often, however, neither is employment necessary. A welfare economy provides some minimum subsistence in even the most deprived areas of the State. Therefore, it would be no surprise that the motivation for a good job is often insufficient to stimulate academic persistence should difficulties arise.

In 1967 the entire interview was reviewed to determine whether the student was internally or externally motivated to seek an education. The differences then were significantly in favor of those who sought an education from some internal motivation. In 1968 the determination was made whether education was for self-improvement, job acquisition, or both. The freshman performance of those who go to school for a job and those who go solely for self-improvement differs ( $p < .10$ ) in favor of the latter for both the 1968 and the total group when judged by these standards.

The 1967 freshmen not enrolled in 1968 were compared with the upperclassmen presently enrolled. Scholastically, of course, the groups are very significantly different ( $p < .001$ ). Those who had not re-enrolled averaged a low "D" (.957) as freshmen and the others averaged slightly above a "C" grade (2.08). The differences between these groups to questions on purpose, value, and motivation for an education ( $p < .10$ ) suggests that in some way the groups do differ in their motivation and in what they feel the purpose of education to be. Further research is needed to understand better the significance of formal learning to Alaska Native students.

The motivation for an education is more than the mere pursuit of a job and the alternatives to school were also considered. They were, essentially, a return to the village, a less skilled job, or both and - with some qualifications - attendance at another school. The student was asked first, under what circumstances would he return to his village permanently. Four students plan to return home (Anchorage, Juneau, Fairbanks, and Nome). Seventeen would return home only if there were a good job available; 19 would not return to their village.

The student was asked what he would do if he had to leave school now. Of the 41, three students would return home and 32 would look for a job. If there were no schools at all to attend (if this was questioned, it was qualified as no schools in Alaska) a different 3 would return home, 20 would seek a job, and 12 would seek their education elsewhere. In each case the rest did not know what they would do.

To the query whether the Alaska Native appreciated education, 24 answered affirmatively, 7 answered in the



negative and 10 didn't know or couldn't say. Reasons given for so few Alaska Native students finishing at the university were that he, the Native student, had poor study habits and he socialized too much (13), he became homesick and too easily discouraged (20). Empathy in these responses is conjectural. Money was not a factor in a student's non-persistence at school. Too many of the students seem to feel inadequate even before they arrive at the university.

The students were asked also what the University could do for them, to insure successful completion of school. Nineteen thought that there was nothing more the University could do other than provide an education, eight thought that more guidance and counseling - as opposed to tutoring - would help, and six thought that a part-time job would ease some financial problems. Seven didn't know. In other words, the greatest need expressed was for someone to help them with their study techniques and someone to counsel them with their personal problems. It may be as Parker<sup>12</sup> pointed out that they have some question how education will help them to achieve their aspirations, and they have some cultural inability to share problems; all of which contribute to the difficulty of adjustment to university life.

### 3. STUDENTS' SATISFACTION WITH EDUCATIONAL EXPERIENCES

Predictably, the students in 1968 as well as the combined groups who are dissatisfied with their educational experiences do poorly and average little better than a "D". Students who appear neutral or positive toward their educational experiences do better; "C" for the 1968 group and "C-" for the combined group. This apparent relationship between satisfaction with schooling and achievement is, however, not predictable in individual cases.

If we separate those students who thought the University could help them from those who felt that there was nothing more the University could do, the differences in freshman performance are quite negligible. There were suggestions that students could use more guidance and counseling (8), more sources of financial aid or work (6), and even one request for tutorial assistance, but 19 students felt that the University was doing its job.

The student was then asked how he would lead his life differently if he could lead his life all over again with what he knew now. While there were many responses, they fell into several distinct categories: "Do the same" (12), "Study harder" (10), "Change life pattern" (7), and "Change school pattern" (8). Understandably, those who would study harder are

poorer students. Those who would not make any life changes in a second chance show the best freshman performance. They felt that their mistakes provided experiences from which they could profit. It would still be most difficult to make predictions about individuals in any of these categories. Almost half the students interviewed found a favorite subject which was outside their major subject area to be unexpectedly stimulating. A longer interim period without a declared major might provide greater opportunity to sample the University fare without commitment and thus achieve a wider exposure to the stimulation a university can provide.

### 4. ROLE OF EDUCATION IN THE FUTURE LIFE OF THE SUBJECT

The manner in which the student sees education contributing to his own future should have some bearing on the intensity of his desire to complete an education. The Alaska Native at the University lives in a moderately fortunate environment. If he can complete his education satisfactorily, i.e., achieve a "C" average over a four year period, his diploma will open a series of preferential opportunities. Although most students interviewed seemed to be vague on the specific requirements for their established vocational goals, it was not unrealistic for them to say that they needed only to register with the University Placement Office for employment. Employment is available in Alaska for any Alaska Native graduate from the University.

Inquiry was made, however, not only of what the student planned to do when he finished college but what he planned to do in the future; twenty or thirty years hence. Of the 18 persons preparing to teach, for example, only six envision this as a lifetime career; six plan to be full-time housewives and the remaining scatter into other occupations such as nursing, anthropology and politics. Most students (23) plan to change occupations in the course of their lives and 17 students plan, now, to remain in the same occupation for life.

An increasing number of persons plan to go into law and/or politics. Although only four persons plan for law and politics immediately after school - and three consider this a lifetime career - eight persons see law or politics in their future. Political action seems to be a self-fulfilling act rather than the result of any idealistic drive.

Although university trained women among Alaska Native people are most rare, more than half the women interviewed plan eventually to be full-time housewives. Only three planned to pursue a career and in some way divide their professional time with housewifely duties.

The ultimate goal for most of the women seems to be to have a family - generally a large one - and to take care of the home. Although this question merits further examination, these women did not seem to feel a strong need to assert themselves as individual persons but preferred to stress a subordinate role for their lifetime career.

The differences in freshman performance between those who plan eventually to change occupations and those who do not is significant ( $p < .05$ ) in favor of the latter. Perhaps the college student who cannot relate his immediate to his ultimate goals possesses a less intense desire to succeed since success will have less meaning in terms of his ultimate goals.

## 5. ROLE OF MODELS

It is often thought that an understanding of his childhood development of models, i.e., ideal persons, for the individual might have some relationship to his performance at the University. Although time did not permit any detailed probe of the formation of ego-ideals, the students were asked about ideal persons. The question frequently required much elaboration and explanation on the nature of an ideal person. The response that the student considered himself as an individual and didn't want to be like anyone else persisted, even after the elaboration of the question. The answers were grouped: no declared model, an individual such as a teacher, parent, or friend, and an historically significant individual. The students who denied an ideal person as a model performed significantly better ( $p < .05$ ) than those with conscious models. The performance of those with friends and relatives as models was between the extremes.

One explanation may be that a conscious and aggressive assertion of the self as an individual may preclude a knowing acceptance of models. There may be elements of aggression involved which are critical for success. It would be a very useful tool to understand better the unique development of the Alaska Native to understand the formation of his models for behavior and action and its relation to his non-competitive society.

## SUMMARY AND CONCLUSIONS

Any serious discussion of results must emphasize the fact that they are based on interviews with only 68 different persons. These persons are not characteristic of the Alaska Native population generally. They are more educated, more sophisticated, and, without a doubt, have a much higher level of aspiration than the generality from which they are drawn. They represent a small and, in one sense, exclusive segment of the

population. Nevertheless, they represent a group from which the potential leaders of the future will be drawn. They are sensitive to political winds in Alaska and many are aware of the racial power struggles elsewhere and the significance of political strength in the United States. The technologic backwardness of rural Alaska has helped only to postpone a revolution of rising expectations in the forty-ninth State. The growing awareness of the inferior social status of the Native in Alaska will provide him with ample occasion in the future to rectify the imbalances.

Whatever the factors at risk the American college student brings to school, the Alaska Native seems to have some that are relatively unique.

First, his family. Although there is no direct statistical relationship between the education of parents and success at school, there is some evidence that little or no education of parents seems to make unlikely the achievement of satisfactory grades the first semester at college. In our group only three persons averaged a "C" grade or better when both parents together had less than 12 years of education.

Second, his schools. The evidence suggests that his segregated schools are inferior. The village schools are *de facto* segregated and his boarding high schools are legally segregated. Recent newspaper publicity on Mt. Edgecumbe, the major boarding high school for Alaska Natives, pointed out that ninth graders are admitted with less than a seventh grade achievement. If the population of this study is at all representative, the high school achievement at the BIA schools predicts success more poorly in terms of university achievement than high school achievement from any other school system. Since other systems in the rural part of Alaska are predominantly Native populated, the suggestion is that the totally segregated education of a large number of Alaska Natives is indeed inferior.

Third, his village. The majority of our group do not want to or cannot return to their village homes permanently under almost any circumstances. A very large number would return only if there were a good job which, too often, is wishful thinking. The student is in the "betwixt" position that if he should not finish school, he will join a large number of marginal and unskilled workers who are drawn to the urban sectors or he can return to the village to eke out a marginal and welfare-oriented existence. Generally, however, he has already educated himself out of the village social orbit. For the village a siphoning of its more talented members threatens its viability - if we assume that the village at present is a viable institution.

Fourth, his role as a student. At the university the Alaska Native suffers from a lack of skill required



to master his environment. According to the students themselves, they are intensely homesick and they do not know how to study. The university provides his first unstructured environment and seems to leave him feeling helpless and unprotected. The timidity, shyness, and general feelings of inferiority of the Alaska Native make it difficult if not impossible for him to seek academic help; he feels unable to question his teachers. He escapes from the situation by withdrawing completely - he simply does not attend classes.

Fifth, the role of women. Unlike the usual academic situations, Alaska Native women students are significantly worse students than the men and they do not persist as long at the university. Further exploration is needed to understand the role of women in the Alaska Native society and to develop the means whereby women may be able to achieve a greater degree of individualism and self-determinism as well as play a significant role in Alaskan society that is of their own making.

Sixth, the meaning of education. Near significant differences occur between those who regard education as a vocational opportunity and those who view it as a means to self-improvement. The differences are in favor of the latter. A good job seems to be less motivating than the opportunity for self-improvement. Some special emphasis on the role of education in the development of one's own self-image may prove to be a more successful stimulus for achievement.

Seventh, the future. The clarity with which the

individual sees his own future also seems to bear upon his performance. The student who sees his educational goals related to his future life goal is a superior performer as a freshman. Conversely, the individual who plans some future other than one directly related to his immediate education goal does not perform as well. He may lack some of the motivation to succeed at school.

The Alaska Native is in a transition and often not very far removed from the hunting and fishing stage of development. Increasingly his continuing contact with Western culture leads him to seek many elements of the sophisticated materialism which are desirable. His own achievement of centuries-long survival under harsh conditions is not now meaningful. His development today is in a cultural environment which stresses that his values are without value. This alone is psychologically unhealthy and has engendered much hostility. The technologic backwardness of the bush has only delayed the intense desire for the myriad of objects which constitute the good life. If the rising level of aspiration should outrun the ability to acquire the good things, racial strife could easily become a part of the Alaskan scene. It seems rational, therefore, that the Alaska Native should attain a stature as to be able to compete in his newly-acquired Western world on the basis of equality. Until he can compete at equality he needs preferential treatment in those areas for which he faces the greatest risks.

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8. These figures and the following are derived, it is hoped, with a minimum of statistical violence. In fiscal year 1966, 3140 Alaska Natives were between 20-24 and 4780 between 15-19 years of age. Using the breakdown figures of the 1960 census when 19-year-olds made up 21.3 percent of the 15-19 year group, 21.3 percent of 4780 (1018) was assumed to be the 19-year-old population in 1966. The SURVEY OF STUDENTS ATTENDING SCHOOLS OF HIGH LEARNING: 1965-1966, Compiled by John I. Eichman, Branch of Education, Bureau of Indian Affairs, Juneau, Alaska, March 1967, lists 229 Alaska Native students enrolled in universities and colleges - many who are non-matriculated students - hence the 5.5 percent figure. For the United States the data were handled similarly. Over 5.5 million persons were enrolled in higher education and 17.4 million was the total population, 19-24 years of age. U.S. Bureau of the Census: STATISTICAL ABSTRACT OF THE UNITED STATES. 1967, 88th Edition, U.S. Government Printing Office, Washington, D.C., p. 133.
9. Foster, Ashley: AN INQUIRY INTO PREDISPOSITIONAL FACTORS INCIDENTAL TO ACHIEVEMENT SUCCESS BY ALASKA NATIVE PEOPLE. Alaska Medicine, September 1968.
10. The word "significant" is used in the statistical sense to mean that the differences would occur 5 times in 100 on the basis of chance ( $p = .05$ ). "Very significant" means that the differences would occur 1 time in 100 by chance ( $p = .01$ ).
11. Ray, Charles K., et al: *op. cit.* p. 86 ff.
12. In *Ibid.* p. 54.

## APPENDIX A

### 1. FAMILY ATTITUDES TOWARD EDUCATION

- A. Language spoken by parents.
- B. First language of subject.
- C. Education of parents.
- D. How do parents feel about subject going to school?
- E. What do the parents expect that education will do for subject?

### 2. STUDENT'S ATTITUDE TOWARD EDUCATION

- A. Does school make any difference? How? Why?
- B. What does schooling do for subject?
- C. Who discouraged subject from continuing in school (school/non-school)?
- D. Who encouraged subject to continue in school (school/non-school)?
- E. Do you think the average Alaskan appreciates the importance of education?
- F. Why do so few Alaskan Natives go to/finish at the University?
- G. Under what circumstances would subject return to village permanently?
- H. Suppose the subject had to leave school now. "What would you do?"
- I. Suppose there were no schools to attend.

J. What should be the end result of a good education?

### 3. SATISFACTION WITH EDUCATIONAL EXPERIENCES TO DATE

- A. What subject does subject like best/worst?
- B. What can the University do to help subject?
- C. Would subject encourage friends to complete schooling? Why?
- D. If you had to do it all over again, what would you do that was different?

### 4. ROLE OF EDUCATION IN THE FUTURE LIFE OF THE SUBJECT

- A. What do you plan to do as an occupation?
- B. How much education is needed for that?
- C. How does one go about to do this work?
- D. What sort of a life do people in this occupation lead?
- E. Have you ever worked for money?
- F. What do you see yourself doing in five years/ten years/indefinite future?
- G. Where do you plan to live?

### 5. ROLE OF MODELS

- A. After whom would subject like to pattern life? Why?
- B. What is subject doing now to accomplish this?



*"On Trail" by Fred Machetanz.*

Presidential Collection, 26 by 32 oil painting on masonite.

This painting depicts a dog team up above the tree line moving out as they go down grade. The mountain background is the Deborah, Hess and Hayes area of the Alaska Range. President Johnson saw this painting when he was in Anchorage in 1966, admired it and when back in Washington referred to it again. Some Alaskans hearing this purchased it for his collection.



# PHYSICIAN PROTECT THYSELF

## Prescription Permit Promoted

Item from AMA News October 7, 1968:

### "Explain Rx Side Effects, Attorney Warns Physicians"

A new concept of malpractice liability has crept into the law as result of a decision of the Washington State Supreme Court, a New York attorney warned . . . referring to a lawsuit in which a physician had prescribed an antihistamine for his patient, a bus driver, and failed to warn of possible side effects . . . A passenger injured when the bus driver fell asleep at the wheel sued bus company, driver, and bus driver's physician . . .

The driver testified that he took his first tablet the morning of the accident, and that after driving a few miles he felt groggy and drowsy. Then, he said, he either blacked out or fell asleep and the bus went out of control.

Expert testimony at the trial said medical standards of practice in the community require a physician to forewarn his patient of the possible side effects of antihistamines. He said these affect about 20% of the users.

The first court returned a verdict exonerating the physician from liability. On an appeal, the appellate court ordered the judgment in favor of the physician to be vacated, and ordered the case tried again.

"A doctor can protect himself from this malpractice hazard", said the attorney. "All he has to do is to add another paragraph to his prescription in the following language:

"PRECAUTION: This pill makes some people sleepy. Do not drive an automobile or operate machinery on which you may be injured until you know what your reaction to it is."

The attorney noted that the Physicians' Desk Reference contains many warnings to physicians with reference to antihistamines . . . (but they are) . . . not included in the prescription packages unless the doctor so orders.

"If the drug company considers it important enough to print a warning on its package literature, which no one but the pharmacist sees, surely the physician would do well to protect himself from liability by adding a precautionary measure to his prescription", he said.

With the current pressure for greater forewarning of risks and side effects, and a public increasingly well informed medically, it seems time to share with the patient more of the knowledge and responsibilities of medical treatment. It appears likely that the patient's signature on a simple prescription permit could obviate later distrust and litigation, by documenting adequate forewarning of possible drug side-effects. It would be simple enough for the drug manufacturer to provide, in common English, a prescription permit listing the precautions customarily recited in the insert or the Physicians' Desk Reference.

Of course such a standardized prescription permit must be properly handled to prevent difficulties of the type referred to in the above news item. It should be signed when the drug is actually dispensed, and witnessed by the pharmacist and a notary public. No permit should be signed by a minor, who can thus receive drugs only when both parents sign for him or when sponsored by both his guardian and his lawyer.

No short forms are to be used except in acute

medical emergency, and then only with consent of the presiding magistrate when witnessed by notary public and pharmacist. Unusually active or dangerous drugs should only be dispensed after an on-the-record conference between the physician, pharmacist, and patient in the presence of lawyers for all parties.

A sample prescription permit has been prepared from the insert of a commonly prescribed antihistamine to illustrate this proposal.

### SAMPLE PERMIT (Long Form)

I, \_\_\_\_\_, being of sound mind and body except in the following particulars:  
a. (for example, "runny nose") b. (etc.) \_\_\_\_\_

c. \_\_\_\_\_ d. \_\_\_\_\_

(use back of form if more room is required) do hereby agree and submit that the following risks and possibilities of unexpected results have been carefully and clearly explained to me and do accept and assume full responsibility for all such results as well as specifically for any other side effect, action, lack of effects, adverse response or future related or possibly related results following swallowing, injection, or insertion by one or another routes, in either the recommended or other dose, the drug now provided or any of its inactive constituents, specifically including the gelatin capsule which could dissolve too rapidly, too slowly, plug an orifice, cause discoloration of clothing or have any other unexpected and undesirable effects. This drug has been suggested to me by Dr. \_\_\_\_\_, Medical license number \_\_\_\_\_, Issued in State \_\_\_\_\_, Date \_\_\_\_\_, who hopes or believes or feels it possible that one or more of the several above complaints (a. thru d.) may respond symptomatically or otherwise be improved to a lesser or greater extent by this treatment. I understand and agree that no guarantee of any effect or result has been given by word or implication by my physician except as herein specified.

I understand that specific precautions and risks of this drug include the possibility that:

(1) I may become drowsy or fall asleep unexpectedly and that if driving or walking or operating machinery or standing or in any position except flat in bed that such drowsiness or falling asleep could cause (a) injury or death to myself and/or one or more other persons, or property damage of an unknown and unpredictable amount. (b) Further, even if in bed I could

roll over and fall out thus injuring myself or that I might have bad dreams which could upset me to a lesser or greater degree with unknown results.

(2) I may become dizzy and unable to keep my balance or may fall at an unexpected time or place with greater or lesser force causing (a) unknown and unpredictable injuries to myself and to others that I may fall on or otherwise injure to a greater or lesser degree or even fatally. (b) In addition, by falling I may land on property of lesser or greater value such as antique objects or on the roof of a new auto if, for example, I fall out of a window, and for this I take full responsibility.

(3) I have been warned that my mouth may become dry, and that should I drink excessively to alleviate this I could easily do as in (1 a.)

(4) I may get nauseated to a greater or lesser extent, and may throw up a greater or lesser amount over a considerable distance and area with a possibility of causing internal injuries to myself and soiling, distressing or otherwise troubling those in the immediate vicinity, who could even slip and fall and thus injure themselves or their property or the property of others.

(5) I might become a nervous wreck, feel very restless, be unable to sleep, become excitable or even have convulsions if I take too much of this drug.

(6) I may become impotent.

(7) My skin may turn red all over and become itchy; it could get full of blisters or even all my skin might fall off, and I could become very sick or die.

(8) I may develop wheezing or shortness of breath or even lose my breath.

(9) My nose may get very stuffy and I might need to breathe through my mouth further aggravating #3 listed above.

(10) I might develop shock and drop dead after taking this medicine.

(11) My heart may beat in a peculiar or rapid fashion causing any type of severe heart problem or anxiety (see #5 above).

(12) My eyesight could become blurred causing me to injure myself or others or damage property (see #1 and #2 above).

(13) I may develop a moderate to ghastly headache which could persist for a long time.

(14) My muscles may ache and pain and cause me to be unable to walk or perform necessary tasks which could cause considerable danger, cost, or injury (see #1, #2, and #12 above).

(15) My phlegm may get thick and stringy and hard to cough up or even to pull out.

(16) I may develop moderate or severe diarrhea or vomiting or both to such an extent that I may be seriously ill or my life be endangered.

(17) My water may stop and my bladder overfill leading to surgery or bladder rupture or other unforeseeable complications.

(18) I further understand that should I now have or possibly develop heart disease, high blood pressure, diabetes or thyroid trouble, I could, of course, get into much worse trouble, and I hereby accept full responsibility for taking this medication for conditions a. thru d. listed above and specifically release all others from liability for side effects #1 thru #18 inclusive.

SIGNED: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ (Pharmacist)

Witness: \_\_\_\_\_ (Notary)

Witness: \_\_\_\_\_ (Lawyer for patient)

Witness: \_\_\_\_\_ (Lawyer for doctor)

Witness: \_\_\_\_\_ (Lawyer for pharmacist)

(SEAL)





# AURORA DENTATUS

## KETCHIKAN

Gary Floyd recently moved into new space. He (and the bank) have one of the town's best looking two story buildings. Beautifully appointed, functionally designed.

The Jimmy Whaleys will probably have a new 1969 deduction sometime in January or February.

The highest winds in Ketchikan's history did little or no damage apparently to our colleagues, though rain was driven in around windows, ventilators, etc. and buildings quivered in protest.

Shep Sheppard reminds us all that dues are now due and payable. Statements are on the way.

## JUNEAU

High winds and snow reported by Norm Riddell didn't deter his deer hunting, although his boy was delayed four days getting home with his two deer.

Clayton Polley hunted the Chickakoff area, termed by some, "The old Man's country", but a favorite spot of many.

As a member of the Pacific Marine Fisheries Commission, Dr. Norm Riddell recently returned from a meeting held at Cour d'Alene, Idaho. Norm helped form this significant group in 1947 and has maintained active interest in the field. He reports progress for Alaska and that next year's meeting will be in Alaska, probably in Juneau.

## FAIRBANKS

New officers of the Central District Dental Society are: B.A. Simonsma-President and A.V. Pflugrad-Vice President.

Bud Fate, as Secretary of the Dental Board, reports a meeting held in Juneau early in December. It was a housekeeping chore basically, together with the Central Licensing Section, including revision of application forms and grading sheets. The Board will compile two information sheets to be sent to inquirers; one regarding general information on dentistry in Alaska; the other will give teaching data on what is expected by the Board to practice Dentistry in Alaska.

Dates for the new exams have been set for July 20 through 25, 1969.

## ANCHORAGE

Joe Cumming is spending several weeks in the Bethel area, bringing good dentistry to some remote areas.

New officers of the South Central District Dental Society are Geraldine Morrow, President; Ward Hulbert, Vice President; and Joe Cumming, Secretary-Treasurer.

Tom Redmond, state chairman and Bob Brodie, local chairman are working hard on their Children's Dental Health Week program and are getting the usual good support of their colleagues. See Tom's article in this issue.

Medicaid (Title XIX) was explored, explained, and discussed by those present at a recent meeting which included representatives of the Alaska State Medical Association, the Anchorage Medical Society, (Dr. Rod Wilson chaired the meeting), the South Central District Society, and the Alaskan legislature. Dr. Glen Crawford's excellent presentation and analysis was informative to all. Our legislators need advice and good communications to effectively handle this new feature of our society. It is most important that the professions be knowledgeable and available as resources, and that they retain and enhance the good rapport we have with Alaska's legislators.

Comprehensive health planning in the Anchorage area is yet to be formally assigned by the Borough chairman, John Asplund. Two groups have expressed the desire to function as the local Health Planning Body and both are studying concepts, methods, etc. in preparation for this task.

## BAGGEN NAMED TO JUDICIAL POST ON QUALIFICATIONS

Dr. Eddie Baggen of Fairbanks and Robert B. Atwood of Anchorage were recently named to the new state commission on Judicial Qualifications by Gov. Walter J. Hickel.

The commission was authorized by the 1968 Legislature and by the voters in the August 27 Primary; it has as its purpose, action on the disqualification, suspension, removal from office, censure, and retirement of judges and justices.

Dr. Baggen and Mr. Atwood will be joined on the commission by a member of the State Supreme Court, two judges of the Superior Court, two District Court judges and two members of the Alaska Bar Association.

Dr. Baggen served as President and as a five year term member of the Fairbanks School Board, as well as two terms in the State House of Representatives. Mr. Atwood, Editor and Publisher of the Anchorage Daily Times, has long been active in state and local affairs.



## DELEGATE REPORT

It has been my privilege to serve as your delegate to the American Dental Association for the past four years. During two of the four years, I served as one of five delegates on two reference committees of the house of delegates. In 1966 on the committee on the president's address and administrative matters, and this year on the Federal Dental Services Committee.

Last year it was my pleasure to serve as the vice-chairman (presiding officer) of our 11th district caucus.

The major actions taken by the house of delegates during these years were:

1. The creation of the National Association of Dental Service plans, a "coordinating agency".
2. The ADA children's program.
3. Guidelines for dental care program for dependents of military personnel.

This year, of particular interest for Alaskan dentists, is the review of "remote" classification of military bases. The report of the Council of Federal Dental Services specifies that only civilian population and civilian dentist figures be used in determining ratios of dentists to population.

The NADSP is now being promoted as the vehicle for a profession sponsored national prepaid dental care plan.

The proposed dues raise of \$20 was not approved, but a raise of \$15 was.

The matter of continuing education requirements for re-licensure moved a step closer to reality.

The many complications associated with the practice of dentistry under Medicaid, as in the state of New York were again reviewed. It behooves the dental community of Alaska to begin immediately to

work with the state in this area, as well as in the area of comprehensive health planning.

In the area of prepaid dental plans, I was able to learn from members using the "foundation type" of service corporation that they have experienced difficulties and have changed to the underwriting type of service corporation.

Other than administration of dental plans by the Blue Cross or a similar organization, the only other vehicle available to us is a strong standing committee on prepaid dental programs. The Indiana Dental Association has published a manual on this type of administration, which warrants our immediate and thorough study.

This committee would also deal with dental treatment under Title XIX (Medicaid) and comprehensive health planning.

There are now three seats for Alaska on the floor of the house of delegates. One for the delegate, one for the executive secretary and one for the state secretary. It would be a great help if arrangements could be made to utilize more than the one we are currently using.

It has been a most interesting and rewarding experience to serve as your delegate these past years, and I wish to thank all of you for the opportunity.

Luther L. Paine, A.B., D.D.S., F.A.C.D.

## THOUGHTS ON COMPREHENSIVE HEALTH PLANNING

In a recent commencement address, the Honorary Melvin R. Laird (Republican from Wisconsin), who has just been appointed by Mr. Nixon to the cabinet office of Secretary of Defense, stated that, "What we need is a determination that we shall neither lose sight of our past nor control of our future". (1054, J.A.D.A., Vol. 77, November 1968.)

Item: 63% of New York City's dentists participate in Medicaid. \$62,284,000.00 spent for calendar year ending August 15, 1968, an average of \$12,261.00 for each participating dentist. Of the 2.4 million city (New York City) residents who were initially covered by Medicaid, only 1.4 were still Medicaid card holders as of July 1, 1968. Among those eliminated, 260,000 did not re-apply. The others were declared ineligible.

"Reminds me of my first honeymoon--no one knows what they're doing, but everybody laughs!" Zsa Zsa Gabor.



# JOIN THE SMILE IN

By Tom Redmond, D.D.S.

*State Chairman, Dental Health Week*

February 2-8, 1969, heralds the 21st National Children's Dental Health Week in America, and for the first time, Alaska will have a truly active statewide program sponsored by the American Dental Association and its component state societies.

In keeping with the times, I urge all dentists (and physicians) to join "The Smile In" for 1969, by calling attention to observance of that week and actively participating.

This annual event is organized to accentuate the importance of dental health beginning with childhood and continuing throughout life.

As professionals, we all realize dental health is an integral part of total health and we must be concerned that large segments of the population, especially in Alaska, still do not give proper attention to their dental health.

Statistics compiled through surveys conducted by the A.D.A. point out some startling facts about the nation's dental health problems:

\*More than half the people in the nation fail to see their dentist during the year.

\*About 50% of the children in the country under 15 years of age have never been to a dentist.

\*Less than one-third of the population brushes their teeth more than once a day (a significant factor in our "rapid pace" society of hasty meals and snack foods of high refined carbohydrate content).

\*The average two year old has at least one decayed tooth; by the fifteenth year, he can be expected to have 11 decayed teeth.

\*Gum disease (pyhorrea or periodontal disease) often begins in childhood and is the most significant cause of tooth loss in adults.

The unfortunate aspect of such statistics is that the majority of these dental problems would be vastly reduced with proper care -- both at home and in the dental office.

What are we, as a profession, doing to change all this?

More than 82 million Americans are drinking fluoridated water. Some 72 million have controlled fluoridation and another 10 million live in communities with naturally fluoridated water. This can lead to a 65% reduction in caries incidence and is the most effective means of controlling dental decay at present.

Fortunately, more and more, the value of fluoridation is being recognized by our elected officials and men of influence. In certain states, including Illinois, Connecticut, Delaware and Minnesota, the fluoridation of public water supplies is required by law -- Alaska take note!

Dental scientists at the National Institute of Dental Research have found that an experimental enzyme called dextranase can successfully prevent and retard tartar formation and decay in hamsters. The investigators say the progress of decay in the hamsters studied is so inexorable, that the success of dextranase is extremely impressive.

In all this year, there are some 3,700 research projects in the U.S.A. alone which are concerned directly with teeth and dental health. The researchers are using everything from barnacles to baboons, clams, oysters and sea worms.

Unfortunately, it will probably be some time before practical application of these and other research findings will be realized.

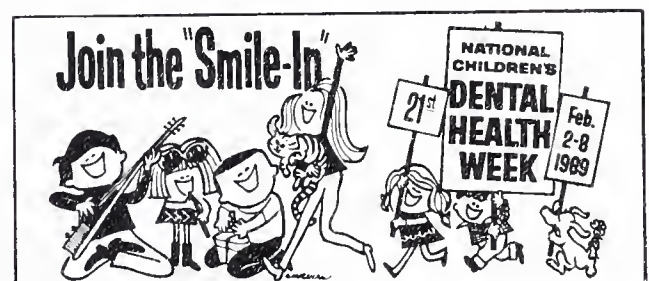
Last year, we reached 4,400 second through fourth grade school children in school visitations of the Greater Anchorage Area Borough School District alone. This does not include the five hours of television exposure, radio spot announcements or newspaper coverage.

What a giant step forward it would be if we could do this in each and every school district of our great state this year (1969). Won't you help make the 1969 National Children's Dental Health Week a success in your area by cooperating with your local chairman in educational school and news media programs. Stick your neck out and stand up for progress! Make your opinions known and your influence felt through your legislators -- support programs for fluoridation.

Let's all join the "Smile In" for 1969 and have a Dental Health Week for Alaska of which we can all be proud.

Here's a list of the local chairmen: find the name of the man rowing the boat in your area and man an oar!

- |                     |           |
|---------------------|-----------|
| 1. Charles Bailie   | Kenai     |
| 2. Robert Biggs     | Juneau    |
| 3. Robert Brodie    | Anchorage |
| 4. Blake McKinley   | Kodiak    |
| 5. Arnold Pflugrad  | Fairbanks |
| 6. Lawrence Putnam  | Cordova   |
| 7. Richard Williams | Seward    |
| 8. James Van        | Ketchikan |
| 9. Ted McDow        | Sitka     |



# COLD INJURY: REPORT OF AN UNUSUAL CASE

By James A. Wilson, M.D.  
and Arthur N. Wilson, Jr., M.D.

The purpose of this paper is to relate our combined experiences with a rather unusual case of cold injury involving prolonged cold exposure treated with several modalities including a portable hyperbaric oxygen tank.

On February 17, 1965 after it had snowed over 12 feet in three days in the mountains of Southeastern Alaska and Western British Columbia, an avalanche occurred partially inundating the Granduc Mining Camp in Northeastern British Columbia. Because of the inclement weather, evacuation to any nearby Canadian facility was impossible, and a medical team and rescue force were dispatched from Ketchikan, Alaska, to supervise early treatment and evacuation of most of the miners.

Approximately 79 hours after the avalanche occurred, a husky, young carpenter was uncovered deep in the snow. His discovery was inadvertent as a bulldozer was being used to clear snow away from the helicopter pad and fortuitously the blade lifted off snow and exposed the patient. The patient was found to have been pinned horizontally on his right side in a building as it was crushed by the snow. He had lain with his right arm extended over his head, otherwise pinned on his side and able to move only his feet in his boots, and his left arm, below the elbow. He was without gloves but had on heavy wool clothes and a stocking cap. Initially, he was knocked unconscious but later regained consciousness and lapsed in and out in a phasic fashion, occasionally eating snow and thinking that he heard the voices of his fellow workers. Rather miraculously, he was the thirteenth found of some 27 people buried and the only one who survived the entombment who was buried more than two hours.

Ambient temperatures during the time he was buried varied between 10 and 15° above zero on the surface. He was uncovered about three o'clock in the afternoon and was immediately transported by helicopter to Ketchikan where he was admitted to the hospital. Oral temperature on admission was 96° and blood pressure 130/76, with regular pulse and respiration, and he had a deeply erythematous complexion. The patient was conscious and responded slowly to questions. He was able to move all of his extremities.

His right arm below the elbow was swollen to about one and a half times normal size and the hand was tense, cold and blue. The left hand showed an area of blueness over the dorsum extending out over the fingers to the proximal interphalangeal joint. The right foot was erythematous and colder than the left

with absent dorsalis pedis pulse. The right lower leg was mottled, purple-white.

After washing extremities with pHisoHex and placing fluffs between fingers and wrapping with Kerlix dressings, a cutdown was placed in the left antecubital fossa and a solution of 5% alcohol and Beclysil was started. A stomach tube was placed and a catheter put into the bladder. The patient was started on hourly antacids and milk and a soft diet and turned every two hours. He was placed on antibiotics, receiving 1,000,000 Units of Penicillin in his first I.V. along with 50 mg Hydrocortisone. He was also given a tetanus booster.

At 4:00 a.m., bloody aspirant was obtained from the stomach tube. The patient continued to bleed intermittently with admission hematocrit of 46 (2-21-65) dropping to 30 (2-25-65) at which time he was given two units of whole blood. During the first 12 hours, he was given Aramine 5 mg for a total of four injections. This was discontinued after the blood pressure was obtainable and was noted to be not only stable but elevated. His temperature rose to 102 axillary the day following admission. During this time, blood pressure climbed steadily to 170/90 - 220/90.

Problems initially confronting us in the treatment of this man included dehydration, hypothermia, damage of unknown extent to extremities and possibly to the endocrine system, the likely problem of a stress ulcer, unknown electrolyte status, and starvation. After early treatment was started, evolution of cold injury began with blood blister formation on the fingers of the right hand, cyanotic discoloration of other fingers and the toes of the right foot, and cool, dry skin on the left foot extending ankle level. Medical treatment continued with fluid replacement, antibiotics and hydrocortisone in a slow I.V. drip, and a bland soft high protein diet.

It was our good fortune and the salvation of the patient that at this time we received the assistance of Dr. William Mills, orthopedic surgeon and Arctic cold weather injury expert, from Anchorage, Alaska. He had just returned from Operation Polar Strike and brought with him Capt. William Sugden and their specialized knowledge and equipment for managing cold exposure problems. Of particular help was a pH meter which showed some very striking facets of our patient's electrolyte problem. Their help was generously given, and there is no doubt that it saved the patient's life and contributed greatly to his rehabilitation by limiting the extent of his injuries.



Despite our clinical expectation of metabolic acidosis secondary to starvation and injury, his initial venous pH was actually 7.74. Immediate correction was begun, and slowly the pH changed to 7.6 and then to 7.4 the following day. He continued to demonstrate alkalosis with values between 7.5 and 7.59 persisting three weeks after admission. During this early period, the patient became moderately uremic and showed a not too surprising elevation of the uric acid from tissue breakdown to a high of 15.6 on 2-23-65, gradually decreasing to 7.1 on 3-4-65. BUN rose from 70 on 2-22, the day following admission, to 150 on 2-23-65, then gradually dropped to 108 by 3-4-65 and finally to 14 on 3-8-65.

There was a great deal of publicity concerning this spectacular and tragic disaster. The day following the patient's arrival, the British Columbia Workmen's Compensation Board contacted us and offered the use of the portable hyperbaric oxygen chamber. A very capable technical representative arrived to supervise the setting up and running of the chamber (manufactured by the Lindy Division of Union Carbide). The first treatment started on February 24, 1965 with the patient tolerating adaptation well. He received a total of seven one-hour runs on the chamber in the following five days. The most spectacular changes occurred during the first run when apparent normal color extended into the left foot and fingers of his right hand. During the successive hyperbaric treatments, the patient developed extreme pain in his extremities, for which he required Codeine.

He was treated with a whirlpool bath on a b.i.d. basis utilizing Betadine as an antiseptic agent in the water and encouraged to use Buerger's exercises three times a day for both legs. Active use of his hands was also promoted. It is interesting to note that serial skin temperatures over the injured foot ranged between 83 and 84° on the plantar surface from March 25, 1965 until April 7, 1965. The evolution of cold injury lagged in the left foot, the first blisters occurring on the 26th and later becoming confluent over the top and the sole of the foot and heel. The right hand showed favorable skin temperatures but gradually gangrenous changes occurred as indicated in the picture.

The patient was transferred to Vancouver, B.C. on April 8, 1965 following amputation of the right second, third, fourth and fifth fingers to the midphalangeal joints because of dry gangrene. When placed under the treatment of Dr. Robert G. Langston, a plastic and reconstructive surgeon, he had dry gangrene of all toes extending a third of the way up into the right foot at transmetatarsal amputation. Dr. Langston noted that the tarsal bones were necrotic and all of the interdigital muscles were soft and jelly-like, as were the

muscle bellies of the plantar muscles of the foot. Following this amputation, the patient's course was prolonged mostly because of circulatory problems of the foot, with dependent edema, swelling, and discoloration of the stump. By mid-July, considerable progress had occurred. He was able to use his hand in a better fashion and to hobble about on his foot. He was eventually fitted with a special boot to fit the amputated foot and was started on occupational and rehabilitative therapy.

DISCUSSION: There are a number of problems raised by this particular case report. We are not able to answer all of these. First, by the time the patient was admitted to our hospital more than an hour and a half had passed since discovery. At the time of admission, oral temperature as noted as 96°. Unfortunately, rectal temperature was not taken, and we do not know what actual core temperature was. We did not go to immediate rewarming but followed an intermediate course of allowing rewarming to occur at room temperature. This was done because we felt we were already committed to a slow rewarming process due to time lapse since the patient was pulled from the snow. The use of 5% DW and alcohol was tried for possible vasodilation and protein sparing effect. Hydrocortisone was added because of concern for possible adrenal insufficiency in the face of such a severe stress. A Curling's ulcer was anticipated, and indeed, some gastric bleeding did occur, but this was handled without any great difficulty. The most interesting and inexplicable finding was the marked alkalosis in the face of an expected metabolic acidosis. These values were rechecked several times, and it is felt that the values were correct.

The hyperbaric chamber sent from the Lindy Division of Union Carbide was an extremely interesting device and seemed to be of considerable help. Union Carbide sent a very capable technician, Mr. Donald Spencer, to assist us in the hyperbaric treatments. By evening on the day after being rescued, the patient was given his first chamber run using three atmospheres absolute for a period of one hour. He tolerated all of his chamber runs quite well with minimal problems due to dysbarism. A total of seven runs over an hour's duration were given. By the last one, a week after being found, the color changes in the left foot were persisting several hours after the run was terminated, and the skin was warm. It was interesting to note that the pain which had not been much of a problem before became very severe during the last few hyperbaric treatments.

In the general evaluation of this patient, it was stressed by Dr. Mills that a persistent and insistent program of physical therapy, including the whirlpool

at lower than normal temperatures, he started on a three to four times a day basis. Betadine was used to decrease the likelihood of any serious bacterial overgrowth. Buerger's exercises were also used in an attempt to increase circulation to the injured parts. Based on extensive cold injury experience, Dr. Mills indicated that the decision for amputation should be made only after 45 to 60 days had elapsed. The program meanwhile was one of gradual ambulation, physical therapy, and treatment of the patient as indicated for preservation of life and well being. It was also his feeling that after expeditious amputation the patient

should be put back into physical therapy immediately to avoid further loss of function.

As the survival rate of people found buried in avalanches for any protracted period of time is negligible, we have felt justified in presenting this case and calling attention to some unexpected changes of pH that may be a part of the answer to the poor response to therapy of such patients.

We would like to thank Dr. Mills and Dr. Sugden, the Lindy Division of Union Carbide, Mr. Spencer, and all of the Staff of the Ketchikan General Hospital whose joint efforts contributed so much to the successful management of this very interesting case.





# BATTERED CHILD SYNDROME

By George Brenneman, M.D.

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This paper presents a general review of the problem of battered children. Many articles cited in the bibliography examine aspects of the problem in much greater detail. The purpose of this paper will be served if the medical profession in Alaska is made more aware of the Battered Child Syndrome and of its role in the management of the problem.

## INTRODUCTION

On January 14, 1968, G.F., a three month old infant girl was admitted to the Public Health Service Alaska Native Medical Center (ANMC), Anchorage, from another medical facility with the diagnosis of subdural hematoma. Parents indicated that the baby was in good health until one day prior to admission when she began to have convulsions while her father was playing with her. Further questioning evoked resentment from the parents, although the father did express several times that he must have played too roughly with the baby. A lack of concern regarding the baby's condition was noted in the parents.

The baby appeared malnourished. She was rigid, unconscious and convulsing. Bilateral subdural hematomas were aspirated twice or once daily for three weeks. Whole body x-rays revealed a healed fracture of the fourth rib, a healed fracture of the left femur, and post-traumatic periosteal elevation of the right tibia.

It was later discovered that at six weeks of age, the infant had been treated elsewhere for a transverse fracture of the left femur, allegedly resulting from a fall from a friend's lap. Battered child syndrome was suspected at that time.

The baby was discharged from ANMC seven weeks later, to a foster home by order of the court. At the time of discharge she was retarded for her age, and it was expected that she would have permanent brain damage.

Another characteristic battered child case is that of C.W., a one-month-old female infant admitted to ANMC on January 6, 1967, because of a spiral fracture of the right femur. This injury was said to have occurred when the mother's boy friend turned the baby over in preparing to give the girl a bottle. The mother felt that her boy friend may have been too rough.

On investigation by Social Service at ANMC, the mother was found to be emotionally unstable and separated from her husband. Since her separation, she had lived for extended periods with two other men,

and the present boy friend was stated to be the father of the infant involved. It was also noted that one year earlier, the mother brought the oldest sibling of C.W. to the clinic because of multiple bruises and burns. Social investigation was made at that time, but no action was taken. Four months later, her next older sibling died at home for unknown reasons at the age of six months.

These findings influenced ANMC to refer C.W. to the Alaska Department of Health and Welfare with the hope that protective action could be taken; however, the infant was discharged to her mother. Three months later, C.W. was found dead when the family arrived at Whitehorse enroute to Seattle.

## I. HISTORY

Battered child syndrome is being recognized with increasing frequency in our country. Over the past 10 years, it has been studied intensively by physicians, social workers, lawyers and legislators. Tragic cases like the two just presented make us sharply aware that Alaska is by no means immune.

The first case of child abuse to be put on record in this country was reported by a nurse in April, 1874. The case was reported to the American Society for Prevention of Cruelty to Animals, and prosecuted by reasoning that the child involved was, after all, a member of the animal kingdom.<sup>12, 26</sup>

Caffey in 1946 reported six cases of infants who presented with subdural hematomas, but with no history of previous trauma. In these cases, 23 additional unexplained fractures were found. No predisposing conditions were detected that would explain the fractures.<sup>3</sup> Lis reported a similar single case in 1950, but no hint of possible etiology was offered.<sup>14</sup>

In 1953, Silverman suggested that the cases presented earlier by Caffey were due to deliberate injury by the children's caretakers, and he presented three additional cases to support his thinking.<sup>19</sup> The environment was implicated fully in a study of battered children made by Woolley and Evans in 1955.<sup>12, 22</sup> It was noted that the children studied were invariably from unstable homes and did not develop new lesions when removed from the environment where the injury occurred.

Since these initial reports, medical, social and legal interest has soared, which is reflected in the volume of specific information that has become avail-

able over the past 10 years. Further, communities have developed an interest and taken responsibility for the abused child. In practically all states, there is some form of legislation attempting to deal with the problem.

## II. CLINICAL ASPECTS

### A. Incidence

Meaningful statistics regarding the incidence of battered child syndrome are difficult to obtain, and the development of central registries to collect statistics has been relatively recent. Saint Vincent's Hospital in New York reported two cases of battered children each month in 1964. The Social Service Department of Cook County in Chicago deals with 10 new cases daily.<sup>12</sup> The American Humane Society collected 662 cases of child abuse in 1962 by reviewing newspapers from 48 states and D.C. Four thousand cases of neglect in all forms come to the attention of New York City courts each year.<sup>12</sup> After the Illinois Department of Children's and Family Services set up a central registry in 1966 in conjunction with mandatory reporting laws in that state, 363 children suspected of being battered were reported in the first nine months of operation.<sup>11</sup> It has been estimated that there are 10,000 cases of battered children each year in the United States.<sup>12</sup> No statistics are available for the State of Alaska, although Anchorage school authorities note some 10 to 20 cases of abuse each year.

### B. Morbidity and Mortality

The importance of the battered child syndrome is only partially reflected in its incidence. The morbidity and mortality is remarkable, exceeding that of many rare childhood diseases (leukemia, cystic fibrosis and muscular dystrophy) which have received a disproportionate amount of medical attention and sympathy.<sup>18</sup> One series of 363 cases collected from 71 large hospitals during a one-year period showed that 33 of the children died, and 85 suffered permanent brain damage. Another group of 662 cases had a 25% mortality.<sup>12</sup> These two reports deal solely with the outcome following the initial insult. When children are returned to the same environment where the first battering occurred, mortality has been reported to be from 20% to 50%, in addition to those who live and are permanently brain damaged.<sup>23, 25</sup>

### C. Diagnostic Aspects

Diagnostic aspects of battered child syndrome are similar to cases of trauma due to other causes, but many unique features are to be noted. All reviews and studies show that the very young are more severely affected. Thirty to 59 percent of the children are under one year of age,<sup>11, 12, 15</sup> and more than 90 percent are under three.

The major diagnostic finding in histories leading to the diagnosis of battered child, is the discrepancy between the clinical findings and the data presented by the persons caring for the child. Repeated injuries not accountable to some physical incapacity of the child should arouse suspicion. The physician may note while obtaining the history that the parents exhibit a lack of concern for the child's condition and evade questions or give contradictory answers regarding the circumstances leading to the injury.<sup>6, 12, 18</sup> The physician must be aware that in cases of battered children the history is faulty. The lack of information logically correlated with the condition of the patient contributes to positive diagnosis. As an example, one mother declared that the subdural hematomas found in her eight-month infant were caused when the child hit himself with his bottle.<sup>12</sup>

The physical findings are those of any trauma case. In addition, extra lesions not related to the presenting complaint are often visible, which may indicate previous neglect. The child's nutritional status is sometimes noticeably poor. In one review of 50 battered children, 25 had disability of an extremity, 16 had skin lesions (bruises, impetigo and lumps), 12 had convulsions, 12 were failing to do well, four had vomiting and diarrhea, and three were found to have large hearts.<sup>15</sup> As that review supports, battered children often have multiple problems related to abuse and neglect.

The most characteristic clinical aspect of the battered child syndrome is found in radiographic study of the child. It is felt by some that diagnosis can be made on x-ray findings alone, discounting the history. Multiple fractures involving bones which appear to be at various stages of repair are typical findings. The injuries appear as detachments of small flakes of bones from the metaphysis, at times detachment of the periosteum due to hematoma formation and rarely complete epiphyseal separation. It would appear that these injuries are a result of using the extremities as handles, thus subject to severe traction and torsion. Reparative changes can be expected to appear eight to 12 days following the injury.<sup>13, 8</sup> Differential diagnosis includes osteogenesis imperfecta, scurvy, rickets, syphilis, osteomyelitis and infantile cortical hyperostosis.<sup>9, 13</sup>

### D. Social Aspects

Although battered children come from families of all socioeconomic groups, educational levels, races and religious sects,<sup>25</sup> some rather consistent characteristics are revealed when the homes of battered children are studied. The majority of families involved show poor integration into the community and a high percentage have serious social problems, such as marital discord, and financial difficulty.<sup>26</sup> The social problems



are generally amplified by personal problems of the parents. Personality characteristics of the parents frequently were identified as hostility and aggressiveness, compulsion and rigidity with lack of warmth, and passive dependence. Emotional age seemed to be more important than chronological age, for teenage parents as a group were not guilty of child abuse. Parents responsible for battering children were themselves often emotionally deprived as children.<sup>12, 15, 26</sup> As more data is gathered, it is appearing that the battered child is a symptom of much deeper underlying social and psychiatric problems. This fact must be kept in mind as we, the physicians, meet and treat the battered child.

#### E. Prognosis

Some data presented so far hints strongly that the long term prognosis of the battered child is poor. Elmer and Gregg studied 50 children over a 13-year period following the initial injury.<sup>7</sup> Out of the 50 children, eight died and five were institutionalized for severe retardation resulting from the initial insult. Fifty percent of the children still living who could be studied in family settings were mentally retarded. Only a few of these showed prospects of becoming self-sufficient adults. One-third exhibited physical defects. It was also evident that the children placed in substitute homes did much better, intellectually and physically, than those placed back in the home where the original injury occurred.

### III. PHYSICIAN'S ROLE

The physician is usually the first person to see the battered child. The diagnosis may enter his mind but is easily dismissed because it is hard for him to accept the existence of such cruelty in our society. Furthermore, it is easy to identify with the parents. Once the physician suspects that the child he is dealing with may be a battered child, however, he must face his responsibility to make the correct diagnosis and initiate treatment just as he would in any other disease. The battered child is a symptom, and treatment extends far beyond the mere care of the injuries.<sup>2, 6, 23</sup>

The involved physician is the key to proper handling of the battered child syndrome. He must initiate and see that help is obtained from various health and welfare authorities and legal agencies.

Legal agencies become involved because abuse of the child frequently is classified a crime. This aspect of the handling of the battered child touches a sensitive area in most physicians. We see ourselves as healers, not as police investigators or judges. However, the knowledge that the injured child usually reflects inner turmoil of the adult who inflicted the injury, and that the child or infant is defenseless and often unable to express himself, should help to light our path of action.

The child's rights must take priority and medical evidence and opinion must be clearly stated on behalf of the child. It would be unfair and unjust to the child, for the physician to hide behind the sacrosanct doctor-patient relationship as a rationalization for not dealing fully with all aspects of the battered child.<sup>2, 17</sup>

### IV. LEGISLATIVE ASPECTS

#### A. Alaska Law

Most states have enacted legislation to provide direction and protection to those who find themselves involved in a case of child abuse. To varying degrees, this legislation protects the physician, parents and children. The State of Alaska has such a law which was amended in the recent Legislature.

Alaska's law directs that not only physicians but other health personnel, social workers and school teachers shall report cases where there is cause to believe that abuse has occurred. This is broader than the laws of some states which require that the only reporting professional be a physician.

The phrase "shall report" in the Alaska law implies demand and evokes a moral obligation, but does not call for a penalty if a report is not made. A law is not truly mandatory unless willful violation of the law is considered a misdemeanor. Many states have such a provision.

The law also provides that reporting be made to the Department of Health and Welfare, which is generally considered more desirable than reporting to the police. It is requested that an oral report be made immediately unless the reporter is in an area where this is not possible. A written report must be made within 24 hours of the discovery of the injury, even if an oral report has been made. Copies of the reports are filed in a central registry and are available to physicians if needed.

The law implies that it is of greater value to make a report as a protection of the child than to adhere to the privileged communication of the doctor-patient relationship. No definite statement regarding these conflicting values is made, however.

#### B. Pro and Con

There are strong differences of opinion regarding mandatory reporting of battered child cases. Canada has been slower than the United States in enacting mandatory reporting laws.<sup>1, 4</sup> Some physicians feel that reporting becomes an end in itself, and the problem is placed in the hands of untrained people, who are not oriented to the broad social and psychiatric aspects of the syndrome.<sup>5</sup> Much of the conflict and negativism regarding mandatory reporting centers on the problem of who receives the report. Many laws provide that the physician report to the police. This immediately places the physician in the position of implying guilt

before it has been established. It also implies that punishment is needed, but does not provide for adequate treatment. From the position of the physician it is much more desirable to report a case to a social agency which is better equipped and oriented to ferret out all the necessary data before any type of legal action is taken.<sup>16, 20</sup>

There are advantages and disadvantages to required reporting.<sup>17</sup> A law requesting a physician to act on reasonable suspicion, based on his expert opinion and professional experience, releases him from acting as investigator or infallible judge. A law requiring reporting relieves the physicians conflict between privileged communication and concern for a child's future, by placing concern for the child uppermost. The physician's mind can be at ease regarding the possibility of a law suit and unfavorable publicity in the presence of a law which provides immunity from such charges. Knowing that he will be required to report helps to eliminate bias, which may exist in even the most conscientious physician.

On the other hand, reporting laws may increase the hazard for the injured child because the parents are reluctant to bring the child to medical attention for the fear of publicity. It has been noted in some

areas, that incidence appeared to decrease when reporting laws were put into effect. It is reasoned that actual occurrence is unchanged, but parents do not bring children to medical attention as readily for fear of unfavorable action. Regardless of skill and tact on the part of the physician, the accused parents will remain hostile toward him and may direct their hostility further toward the child. No reporting law can guarantee freedom from hostility on the part of the parents toward the doctor. A mandatory reporting law often fails to take action for the needs of the siblings.

Whether or not a reporting law exists, the goal of every physician dealing with a battered child must be protection of the child and treatment of the underlying disorders. Even if there is a reporting law, the desperate needs of the battered child will never be met unless the physician is willing to take responsibility and leadership. With adequate legislation and conscientious physicians, battered children still will continue to be battered unless medical, social, welfare, legal and prosecuting agencies can bring themselves to communicate and cooperate. All have a vital part to play in this problem of society, and certainly it is a broader problem than any one person or agency can handle.<sup>16, 21, 26</sup>

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## BATTERED CHILD LAW

Source HB 300 am S	Chapter No. 72	cause to believe that a child has suffered injury as a result of abuse, neglect or starvation shall report the injury in accordance with sec. 20 of this chapter.
AN ACT		
Relating to reports of injuries to children caused by abuse, neglect or starvation.		
BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:		
* Section 1. AS 11.67 is amended by adding a new section to read:		
Sec. 11.67.005. DECLARATION OF PURPOSE. In order to protect children whose health and welfare may be adversely affected through the infliction, by other than accidental means, of physical injury or physical neglect requiring the attention of a practitioner of the healing arts, the legislature hereby provides for the reporting of these cases by practitioners and others to the appropriate public authorities. It is the intent of the legislature that, as a result of these reports, protective services shall be made available in an effort to prevent further abuses, and to safeguard and enhance the general welfare of the children in this state.		
* Sec. 2. AS 11.67.010 is amended to read:		
Sec. 11.67.010. PERSONS WHO SHALL REPORT. (a) A practitioner of the healing arts who, during the examination or treatment of a child, has cause to believe that the child has suffered physical injury as a result of abuse, neglect or starvation shall report the injury in accordance with sec. 20 of this chapter.		
(b) A school teacher or social worker who, while acting in an official capacity, has		
cause to believe that a child has suffered injury as a result of abuse, neglect or starvation shall report the injury in accordance with sec. 20 of this chapter.		
* Sec. 3. AS 11.67.020 is amended to read:		
Sec. 11.67.020. REPORTS. (a) An immediate report of the injury shall be made to the nearest office of the department. All oral reports shall be followed within 24 hours by written reports.		
(b) Oral and written reports shall contain		
(1) the names and addresses of the child and the parents or guardians, if known;		
(2) the child's age and the nature and extent of the injury, including evidence of previous injuries, if known;		
(3) information which might assist in determining the cause of injury and the identity of the person or persons responsible for the injury.		
* Sec. 4. AS 11.67 is amended by adding a new section to read:		
Sec. 11.67.065. CENTRAL REGISTRY. Copies of all written reports received by the department shall be forwarded to all departmental district offices. Reports and other pertinent information received from the department shall be made available to any licensed physician, dentist, chiropractor, religious practitioner, or probation officer, and to any agency offering child protective service.		
Approved by Governor: April 6, 1968		
Actual effective date: July 5, 1968		



# NOME CLINIC

## August 17-31, 1968

By Milo H. Fritz, M.D.

The salmonberries, blueberries, and crowberries were more abundant this year than they ever have been in the memory of the oldest inhabitant. During the time that we were free from medical chores, we drove 82 miles along the Kougarak Road one day, 72 miles to Teller and back, and on one Sunday we drove eastward under sunny skies toward the village of Council.

Everywhere on the green hills, absolutely devoid of trees, were groups of The People picking berries. They went out in old trucks, passenger cars and motorcycles, usually making it a family affair from the oldest grandmother down to the smallest infant snuggling inside the back of its mother's parka.

There is a spaciousness to the Nome area that one cannot experience except above the timber line in other portions of Alaska.

This was the lush time of mid-summer and the lichens, bushes and grasses had not begun to turn their magnificent autumn hues. Still, there were different shades of green from the somber green of southeastern Alaska to olive green along certain slopes, merging into purples and grays as the sun began to set.

The gold dredge that we watched in operation last year has been shut down because they could not make a profit. One continues operation beyond Council, but we could not reach it by car. The hulks of seven other dredges are visible from an airplane a hundred feet above the ground level at Nome. One of these has been put back in operational condition by a Mr. Swanberg, husband of one of the public health nurses who worked with us. It is to be used as a tourist attraction which it will surely be.

Wien Alaska Airlines and Alaska Airlines supply each of the visiting tourists with a colorful summer parka, and these costumes add color to downtown Nome as their wearers visit the curio shops, gather in the hotels, climb onto the buses, and visit the attractions of a by-gone era here in Nome.

Our operations, as usual, were centered in the Maynard McDougall Memorial Hospital, now in a difficult situation because of the imminent departure of Mr. Tom Mercer, who was the hospital administrator. There is also some doubt as to whether or not the United States Public Health Service will continue using this facility instead of transporting all so-called beneficiaries either to the hospital at Kotzebue or the one at Anchorage.

In Sitka, Juneau, Anchorage, and Fairbanks, the

number of the U.S.P.H.S. beneficiaries constitutes so small a percentage of admissions that such a policy would have little or no effect. But here, where 85% of the patients qualify as beneficiaries, the withdrawal of U.S.P.H.S. funds will inevitably result in the closure of the hospital and the departure of the town's only physician with no replacement in sight.

I was invited to the meeting between the Board of Trustees and the U.S.P.H.S. surgeons. Complaints aired by the Board were met with the bland, time-worn cliches of no money, reinforced, of course, by the stringency occasioned by the increased taxes and the retrenchment in government spending. As usual, when members of the Board asked why travel funds could not be used for patient care, the U.S.P.H.S. physicians said that it was a Congressional Law that funds could not be transferred from travel account to patient-care account, or into any other category.

One of the Board members, a Mr. P., more sophisticated than the rest, put his finger on the difficulty when he said that there was no law of the land requiring the rigid expenditure of money, that it was merely a regulation of the Secretary of Health, Education and Welfare and there was a vast difference between law and regulation. This, of course, is the truth, but those who blandly meet the objections of people throughout the State to the wanton expenditure of transportation money, asking that it be transferred to patient care, always are thrown this sop that the funds are rigidly disbursed. But, of course, the people of Nome, like the people of any other city in Alaska, have a very small chance indeed of ever meeting with the Secretary of Health, Education and Welfare to explain the situation so that he can understand it and see the trouble that this rigid policy imposes.

While working in the hospital, Dr. Joseph Cumming, the dentist from Anchorage, saw private patients, and a young cardiologist from Anchorage U.S.P.H.S. Hospital, was here examining suspected or known cardiac cases to be further evaluated at the annual Heart Association clinics.

My wife Betsy and I set up the clinic the weekend of our arrival. The first two days were used to diagnose ENT problems. We then had five days of surgery, with anesthetics given by Mrs. Margaret Acree, R.N. of Anchorage. As there is no anesthesiologist in this area, she was asked by the M.M.M. Hospital to perform this service. I was assisted by my surgical nurse,

Mrs. Levia Childs, who not only assisted with the surgery, but also did considerable teaching. The principal student was Mrs. Pat Weatherby, who had helped last year during the EENT clinic. Mr. John Spahn, Guild Optician from Anchorage, came later to dispense the spectacles that I ordered after having refracted those who were on the list.

It should be of interest to those in private practice to know that 66% of the patients that I saw on a private basis in the clinic were so-called beneficiaries of the Alaska Native Health Service. Last year we estimated 5% of patients would be The People and the true percentage was 45%. A survey revealed that they took advantage of this clinic, private medicine, and the purchase of spectacles because, in their words, they were "seen more promptly, examined carefully, and the glasses arrived within a few days and fit" their facial contours. They also said, "the kids who have tonsils out are in the hospital only two days and don't have to go to Kotzebue or Nome where we never hear from them." Most of the cancellations and "no shows" were not among The People, but among the white Anglo-Saxon Protestants.

Requests for appointment were, for the most part, mailed in from the doctor's office or from the hospital office, but some people had written to us on their own or telephoned.

We travelled by jet both ways, bringing with us almost 1000 pounds of freight besides our hand baggage. In the olden days by DC-3, it took as long as three days. Now the jet does it in one hour and twenty minutes.

We stayed in the North Star Hotel in Apartment A which is right on the sea wall where the Bering Sea breaks and lulls one to sleep every night without the need of pills since this music drowns out the racket of hotel life.

We ate our meals either in the hospital or in the hotel, and on almost every occasion, walked a half-mile or so between the two places employing different routes in order to see the homes, the people, and as much of Nome as possible. Our trip on the Kougarak Road was made in the hospital Toyota. On the Teller and Council trips, we used a rented Rambler station wagon which we obtained through the good offices of a local trucking firm.

At night, John Spahn and I often walked along the waterfront and the sea wall, enjoying the setting sun, seeing the youngsters play along the beach, and inspecting the boats tied up in the harbor and speaking to the men on board.

The City of Nome now has some streets with sewers. This year they are constructing a water system running from Moonshine Springs four miles into town. The sea wall has assured permanence to

the town site, but little new construction has taken place in town and it is difficult to understand what keeps the city going. With the gradual increase in the price of gold, mining may once more become the backbone of the economy. But meanwhile, the dredges rust, the great electric diesel driven power plant of the United States Smelting, Refining and Metal Company stands idle. Young teenagers wander around the streets without jobs and with few amusements.

One of the attractions of Nome used to be the mournful howling of the sled dog. This is almost shocking by its absence. Now instead of the families of The People going out as a group to catch, prepare and dry fish for family and dogs, they buy a snow vehicle on time and charge the gas to their credit card. Consequently, The People's children in the early teenage group who have missed the benefit of family effort and the contact with nature that fishing involves are walking the streets of town looking for something to do.

All along the roads described and along the beach are white-wall tents or small cabins that The People and the white people use as summer cabins and as a headquarters for fishing and berry-picking. Everybody that can, gets out to these places on weekends. Some live there continuously during the summer, commuting by car to their jobs in Nome. The youngsters are absolutely wild about going out with the old folks who actually seem to be driven by some inner urge to shuck the trammels of town and get out with nature as their ancestors have done for millennia.

Speaking once more about the old folks among The People; at the meeting between the Public Health Service physicians and the Board of Trustees when the matter of dental care came up, one of the Public Health Service doctors, answering one of The People who was on the Board of Trustees, said that dental care goes first to the children. The lady who asked the question said, well, a lot of the adults needed bridge work, dentures, and other repairs if they were going to be personable and in good dental health. The bureaucrat replied by asking whether she did not think it more important for the children to be cared for than the adults. This again is a time-worn senseless answer. The older people are the repositories of the magnificent Eskimo culture. It's the older ladies who know how to make mukluks and sew fur parkas and it is the older people who understand the lore of the fields, streams, mountains and the sea. To deny them a pair of reading glasses or bifocals, for instance, seems to me a most shortsighted policy. If the older generation cannot teach the youngsters their skills, a great deal is lost, never to be regained. A youngster can sometimes put off for a year or two some of the things that might be



vital for the usefulness of one of the old folks. Since this is my last year as a middle-aged person, I hope I can be forgiven the above musings and ruminations. The bald statistics of the clinic follow:

PATIENTS	
Children .....	215
Women .....	76
Men .....	62
New Patients .....	186
Old Patients .....	167
SOURCE OF PATIENTS	
Nome .....	323
Brevig Mission .....	10
Savoonga .....	6
Teller .....	3
Wales .....	3
Deering .....	2
Elim .....	2
Alakanuk .....	1
Golovin .....	1
Kotzebue .....	1
Northeast Cape (St. Lawrence Island) .....	1
TYPE OF SERVICE	
ENT office visits .....	58
Manifest refractions .....	62
Cycloplegic refractions .....	35
Miscellaneous visits .....	20
SURGERY	
Tonsillectomy and Adenoidectomy .....	30
(general anesthesia)	
Tonsillectomy .....	5
Myringotomy .....	2
Adenoidectomy .....	1
Submucous resection plus Sinus and Turbinate surgery .....	1
Removal of Chalazion .....	1

GLASSES PRESCRIBED	
Single vision lenses .....	38
Bifocal lenses .....	28
Trifocal lenses .....	5

All patients made good recoveries from their surgery and were discharged on the following day with the exception of the nasal surgery patient who has kept in for three days. The post-operative use of 4cc in each tonsil fossa of a mixture of depocerocillin, xylocaine, and depomedrol reduced post-operative pain to almost nothing in both children and adults who had tonsillectomies. We used this in every case where there was no history of allergy or other contraindication. So far, this use in upwards of 3,000 cases over the past three years has resulted in no difficulties whatsoever, with reduced hospital stays, absence from work, and infinitely less pain.

All records, of course, were meticulously finished before we left Nome in order that the hospital and those people who had insurance could collect what was due them. Tonsils and adenoids were not sent in for pathological examination unless there was something about them that made the surgeon wish to have the structures examined. This saved the hospital a great deal of money and, in my opinion, did not constitute any backwards step in scientific inquiry or modern medicine.

So ended another clinic in the Nome area. We hope to be back again in 1969.



# A CLINIC TO ST. MARY'S 1968

By Milo H. Fritz, M.D.

Only two days after returning from the annual clinic to Nome, Mr. John Spahn, Guild Optician of Anchorage, and I set out for our eighth annual EENT diagnostic clinic to St. Mary's on the banks of the Andreyevsky River.

The heavy stand for holding the refractor and other heavy equipment had been sent by air a month ago. Accompanying us were our usual two green ammunition cases full of EENT diagnostic equipment, paper for the necessary administrative chores and simple medications, all weighing about three hundred pounds. They were carried with us in a Fairchild F-27 prop-jet which took us to St. Mary's via Aniak in about an hour and a half.

It was a beautiful autumn day, the coloring of the leaves and the brilliance of the ice and snow on the high mountains making an altogether exhilarating trip.

We were met by Father Rene Astruc, S.J. on the gravel airstrip at St. Mary's. We went by truck over the seven miles of serpentine gravel road to the Mission which, as usual, was electric with activity.

We were given the guest room, liberally supplied with linen, a jar of hard candy to stimulate thinking and a warm welcome by students and staff alike which by itself, makes this annual trek so rewarding.

Lacking any kind of nursing care at the Mission, two young girls from the village, Elizabeth and Augusta (Gussie) Alstrom volunteered to help us. Elizabeth is, at this writing, enrolled as a student nurse in Yakima. It is not unlikely that her younger sister may follow the same profession. Both of these young girls knew nothing about ophthalmology and otolaryngology, but, as has always proved the case among the young native girls throughout the State, they were willing to learn. They mastered the basic techniques immediately and questioned the reasons for what we asked them to do as the clinic went on.

On the basis of what records we had, those patients who were considered in greatest need were seen first. The girls administered the homatropine and paredrine drops for cycloplegia. It was necessary for them to report at seven in the morning to instil these drops in order that the patients would be ready for me to examine by eight.

John Spahn set up his display of spectacle frames and hearing aid equipment in the guest room in which we slept, after we had made our beds and made things tidy.

Always at about ten in the morning and three in the afternoon, when spirits were flagging, the Sisters

supplied us with tea, coffee, and a mound of sweets, ill calculated for keeping trim figures among middle aged and aging visitors.

With their knowledge of the village and the personalities and the customs of the classrooms and the teaching, Elizabeth and Gussie did a masterful job in maintaining an even flow of patients and avoiding waste of time. On their own, when they saw that, for reasons that they did not fully understand, I was finishing the examination of a group of youngsters faster than five or six an hour, they would call in members of the next group so that they would be ready for their drops and subsequent examination.

Emergencies arose between the routine examinations of the eyes and ear, nose, and throat. One girl had a tremendous abscess secondary to a self administered ear-lobe-piercing job. This had to be incised. Another youngster came in with a frightfully aching tooth that had been eroded almost to the gum line by decay. This we painlessly extracted under local anesthesia.

The modest and extraordinarily efficient Village Medical Aide, Theresa Afcan, appeared frequently regarding infections of the nose, lips and face, all of which proved to be impetigo. I ordered long acting bicillin for them. She administered one million two hundred thousand unit dose in the patient's home daily and I saw these patients every morning. She was most devoted and interested. Her terse descriptions of what was wrong with her patients over the radio to the Alaska Native Health Service doctor at Bethel were masterpieces of complete useful information which would do credit to the most sophisticated emergency room nurse calling a physician in a large city. For her day and night care of the people of the village, with no back-up except by means of an uncertain radio schedule, she receives the munificent sum of ten dollars a month!

During the noon hours, John and I walked along the old muddy air strip paralleling the limpid clear Andreyevsky. On its placid waters rested a great tug and barge, the tug drawing nine feet of water, the limits of which were rapidly being reached as the level of the river dropped because there was no rain.

Each dawn and each sunset was more beautiful than the last. The full moon beamed down on us every night through undefiled air. It was indeed extremely difficult to stay on the job examining the youngsters with the temptations of the outdoors so overpowering. The shouts of the youngsters going out to pick berries or going on picnics made the job even more difficult.



But, the goal was always kept in sight so we managed to keep on the job even though our hearts were sometimes with the people outdoors.

The young volunteer teachers recruited from all over the United States were a comely and energetic bunch. Across the hall from my eighth grade classroom where I did my chores, a young girl named Jackie Anderson was teaching typing. She also is an avid cyclist and on three or four occasions, she and I cycled three or four miles from the village up to the top of the hill toward the airport and then careened down it just for the sake of getting a little exercise, fresh air and contact with the people. She even got John to ride a bike one afternoon - something he had not done since 1940. It is indeed difficult to overestimate the power of a woman, especially one as pretty as Jackie.

The village store was being enlarged and government funds have come through for the construction of a cold storage facility on the banks of the river. The larger boys in the school were occasionally excused from classes to help with the foundation of the much needed girls' dormitory.

Mr. Jim Lee of Anchorage does the heavy equipment work and has given two years of his life as a volunteer in order to teach interested youngsters how to handle this type of equipment.

Mr. Jesse Edge has been retained by the State to teach members of the community carpentry. They gain practical experience working on the girls' dorm.

The berries in the St. Mary's area were as succulent and abundant as they were in Kodiak and Nome. This seems to have been the year of the Berry in Alaska.

At night, after the day's chores were over, I would complete charts, adding the diagnosis from the Standard Nomenclature. But, this time there were no teaching activities since there were no nurses on the Mission staff.

Another volunteer, Miss Mary Travis, has indexed the library, thereby vastly enhancing its usefulness. She is going to try being Father Astruc's secretary. He needs a secretary as badly as I do. His desk is the only one in Alaska that rivals mine for sheer disarray and heaps of various projects in different degrees of completeness.

One evening after work, Brothers Benish and O'Malley had a little party and invited us to view the film UNSINKABLE MOLLIE BROWN complete with popcorn and soft drinks.

The old frame building that constitutes the main edifice of the Mission is traditionally over-crowded and over-used. All the deficiencies of services and equipment are well recognized by the staff. But they

feel as I certainly do, that it is better to do the best with what one has rather than waiting for the millennium when things will be perfect. This differs so greatly from government operations where if every paragraph of the regulations is not adhered to, the whole program comes to a jarring halt.

Mud or dust, depending on the rain fall, or lack of it, coats everything and the problem of just plain ordinary cleanliness is a tremendous one. The laundry, though improved, is far from adequate. The library is quite inadequate but used to the utmost, and with the new indexing will be even more useful. But still, there is little space for the students in which to read.

Because there are no study facilities in the boys' dorm and because there probably will be none in the girls' dorm when it is completed, the youngsters come to study in the Mission school every night after supper.

The practice of religion is important in the Mission program. This must have a tremendous influence on the characters of the students judging from the really excellent work they produce and their general mannerliness as contrasted with thousands of other youngsters I have seen who enjoy many times the so-called "advantages" that are available here.

One evening, I walked three miles along the river bank to where an old Alaska Railroad barge was drawn up on the banks of Margaret's Slough. The barge was one hundred and thirty-four feet long by about thirty-four feet with a large house on top of it. I dreamed of how this could be repaired so that the hull would be sound. Beds and a diagnostic clinic would easily be placed in the house on top, with living quarters for a staff of four or five. Either under its own power or through being towed, the amount of good that could be done along the lower Yukon would yield a tremendous return in money saved and health bestowed on hundreds of youngsters who will never have a chance because the present private and government medical and nursing facilities are spread so thin, unrealistically conceived, and inefficiently carried out. I walked back over the hills on the soft springy tundra, stopping occasionally to eat a handful of blueberries, feeling much exhilarated and pleasantly weary after days spent in the narrow confines of the eighth grade classroom.

Work done, we packed our gear and the next day, Sunday, Brother Benish in his little skiff, The Grayling, took John Spahn and me up the Andrejevsky River for a fishing trip that will be pleasant to reminisce about, no matter what age I attain. The day was matchless for the most part although there was a slight shower when we ate our lunch along the stream. The river was absolutely clear and limpid. Because it was so low, there were some difficult places to traverse even

with a small outboard skiff. One particularly, had been named by Brother Benish, Narrow Squeak Pass.

That particular day, decked out in the red and gold of autumn, the grayling were bent on suicide. Not only did we catch 46 fish altogether, but also, we could see them biting on our spinners as we pulled them enticingly through the clear water. We caught 41 grayling, four rainbows and one pike.

During one stop on a gravel bank, the three of us did the necessary surgery on the fish so that they were ready for the pan upon our return to the Mission. Mother Scholaatica said that this was the first time in all her years at the Mission that fishermen had ever bothered cleaning the fish! For this reason alone, I think John and I will be welcome back again.

Since it was a windless day, when the time came for us to start home if we were to make it before darkness fell, we drifted along without getting blown onto either bank. We could sometimes go for several miles without becoming tangled in the willows on the shore. Brother Benish fed us stew at lunchtime and we ate as though we had nothing in our stomachs for days. The drifting was especially lovely because there was nothing to be heard except the almost inaudible sounds of nature which became apparent when the noise of conversation and the outboard engine had ceased for a little while.

The next day, we climbed into a 180 on floats for Bethel, and then took the F-27 home to Anchorage where the affairs of the modern world soon engulfed us.

In the middle of our medical efforts, we began running out of homatropine. The United States Public Health Service physician at Bethel kindly forwarded some to us, along with additional long acting bicillin for the village.

There was a mild epidemic of impetigo in the village and at the Mission, mostly among the very young children. Among teenage girls, especially those who had made amateur efforts at piercing their ear lobes for the reception of earrings, frequent severe dermatitis and an occasional abscess developed. Next time I go to St. Mary's, I will bring my little ear lobe piercing set and will perhaps be able to do this little operation without getting the infections that were so common on this visit.

Our medical accomplishments follow. We saw one hundred and thirty-eight out of two hundred and forty youngsters. Seventy-five pairs of glasses were prescribed. The "state rate" for these glasses will be charged each youngster, but Father Astruc will

decide how much of this "state rate" each youngster can pay. No individual will receive glasses or a hearing aid unless he pays something, even if so little as a dime or a quarter.

The leading health problem was, and continues to be, scarred ear drums, perforated ear drums and mastoiditis; all present because tonsils and adenoids are not removed when the indications for these important operations first arise.

Last year at the end of the clinic, twenty-three youngsters with one to eight unequivocal indications for having their tonsils, or tonsils and adenoids, removed were reported. The report was forwarded to the Medical Officer in charge of the Alaska Native Health Service Medical Center in Anchorage with copies to our congressional delegation in the United States Congress. As of this writing, three (!) are all that have been done.

The United States Public Health Service, adamantly, against all reason, continues to object to doing tonsillectomies and T&A's in the villages. We can transport men into outer space. Micro-biologic and micro-laboratory apparatus weighing very little can be transported by air just as easily as my cumbersome equipment can. The equipment for administering a proper anesthetic, a defibrillator, a tracheotomy set and small oxygen dispensing gear can all be transported by air at very small expense. This equipment, brought by a surgeon with either an anesthesiologist or an anesthetist, to the villages where these operations are needed---and this includes most of the villages in western Alaska, could virtually eliminate the disgraceful problem of preventable deafness among the natives. However, officials of the Public Health Service, ignoring the technical advances that make it possible to do laboratory work, give anesthetics, and do resuscitation if it should be necessary in the field, blindly and stubbornly insist that this kind of surgery can only be done safely in what they laboriously call "a hospital environment".

Some means must be found by an aroused and indignant citizenry of our State to force the Alaska Native Health Service to carry out this activity which, I myself alone, without an anesthetist and without the minimum laboratory assistance that would be ideal, have proved possible for many years. Mother, indeed, knows best, but nobody as far as I know has ever designated the Public Health Service and its unimaginative administrators as the mothers to the children of rural Alaska.



# MUKTUK MORSELS

## NOME

The OEO plans to enter the health resources picture here, as well as in Bethel. The Nome proposal is to provide family-oriented preventive medical out-patient services in close cooperation with the Maynard McDougall Memorial Methodist Hospital. If this project is funded in February, 1969, the OEO will bring in a physician, as well as nurses, x-ray, and laboratory personnel for the existing hospital. The Bethel proposal as submitted calls for development of a separate OEO out-patient facility, with close cooperation planned with the Bethel USPHS Hospital. This project apparently has met with little USPHS enthusiasm so far.

Evidently these two programs will be demonstration projects only, as the addition of one physician and staff to either area is unlikely to radically alter regional health practices. No one can claim, however, that sufficient medical attention is now available in either area. The OEO plan to vest control of these out-patient medical facilities in local health councils would appear to have merit. Certainly, past experience with both the Methodist church and USPHS suggests that competent local direction has distinct advantages over direction from afar, as shown by  $E=1/D^2K$  (effectiveness decreases in proportion to the square of the distance times the agency constant).

Of course these OEO projects may not be funded, and if funded may not be renewed after one year. However, the addition of a third medical force to the running battle between Dr. Harold Bartko (at the MMM Hospital) and the USPHS (which controls and funds contract medical care for 85% of Nome patients) should prove interesting.

## TANANA

We understand that a new, larger, and even more unnecessary hospital is to be built here by the USPHS. It will replace the present 23 bed unit (in this village of 700 persons which can only be reached by water or air). Such a peripheral segregated facility as is proposed would be in direct competition to the centrally located Fairbanks Community Hospital now in the planning stages.

Interestingly, plans for such a competitive facility develop quietly while the Department of Health, Education, and Welfare planners preach cooperation and coordination of private and "public" health facilities. Meanwhile, at great expense (to all of us taxpayers) the USPHS continues to transfer sick "natives" from the Fairbanks hospital (where qualified specialist care is available) to the Tanana facility (staffed by general medical officers). Such obligatory transfer for

"budgetary reasons" occurs if the patient is to be hospitalized more than three days, and seems medically inexcusable. Truly separate but unequal; and to think that the private medical men who donate their time and skills to the segregated USPHS for token payment must sign a non-discrimination pledge!

## ST. MARY'S

A USPHS Hospital is planned here.

## FAIRBANKS

Dr. Henry Storrs has been appointed program chairman for the annual meeting of the Alaska State Medical Association in Fairbanks this June (June 4 through 7). The convention will be held on the Alaska-67 Purchase Centennial Fairgrounds and promises to be a good show, so get your paper abstracts and hotel reservations in early.

## GLENN ALLEN

Dr. James S. Pinneo returned to his general surgery practice here in September after a one year absence.

## KENAI PENINSULA

The Kenai Peninsula Medical Society elected Dr. Paul Isaak of Soldotna President at its organizational meeting on November 14, 1968. Dr. Paul Eneboe of Homer is president-elect and Dr. Peter Hansen of Kenai is secretary-treasurer. 7 P.M. meetings at the Soldotna Riverside House are planned on the first Thursday of alternate months after the next (January 9, 1969) meeting. As a first order of business Dr. John F. Lee, Director of the Alaska Native Health Area, will be invited to discuss contract services of the private physician with the USPHS. It was noted that contract allotments were very inadequate and that the physician was being asked to provide services to "native" beneficiaries regardless of whether he got paid or not. It was further the general experience of members that USPHS had unlimited travel funds to bring patients to USPHS facilities for care, but that frequently the lesser amount that might be required for local care was not available in the budget.

In this regard, the continued pressure on the USPHS to provide care on the basis of need rather than race has apparently had a paradoxical result. Now contract services with private physicians will only be funded if need is demonstrated, while free USPHS in-and-out patient services will continue for all "natives", indigent, insured and wealthy alike. Superficially, this appears to be another paper shuffle in the current USPHS buildup, counter to nationwide trends and progress toward the integration of patients and facilities.

## SEWARD

Dr. Ernest Gentles has returned to general practice here.

## ANCHORAGE

Dr. Martin Palmer, a board certified internist from New Orleans has joined the Anchorage Clinic. Dr. Alex B. Russell of Georgia has opened a general practice office at The College Medical Center. Dr. Russell completed one year of a pediatric residency.

Dr. Paul Dittrich has a second son. Dr. Kenny Ashby had his first daughter, fourth child.

The McLaughlin Center appears to have weathered an early administrative change and hopefully will live up to its projected goals.

The Alaska Native Medical Center has plans for the construction of a large new medical complex near the Providence Hospital to replace the present antiquated buildings located at the edge of the earthquake area.

The 10th Annual Heart Association Clinic in September was again a great success. From September 9 through 13 four Mayo Clinic cardiologists toured the state consulting on patients and lecturing on topics preselected by Alaskan physicians.

With two pediatric and two adult cardiologists it was possible this year to split the team to Fairbanks and Sitka simultaneously. The clinic tour was then completed by all four men at Anchorage, providing all areas more consultation and lecture time than in past years, and hopefully not exhausting our guests as much.

This year the Heart Association was fortunate in obtaining financial assistance for team transportation costs from the Regional Medical Program despite rather short notice. The outlook for next year's clinic was slightly clouded but unchanged despite some fiscal pressure from the Seattle office of the Washington-Alaska Regional Medical Program to encourage a switch to a Washington based cardiac team.

Very simply, local control over medical care is lost to the extent that financing is centralized. Even the best intentioned control from a distance is out of contact with local realities. Factors unknown to the RMP office in this case were (1) Crippled Children's Services contract directly with the Mayo Clinic, and presently pay for all cardiac patients under 21 years of age (and they do not wish a change). (2) Most Alaskan physicians have a good relationship with the Mayo group, and the Mayo cardiologists sent up here have always been excellent. (3) Although reasons for visiting Alaska vary, generally any physician who offers to come here either hunts bears or patients. The Mayo doctors don't need the patients and are here as a service to the Crippled Children's program which supports a considerable part of their work in Minnesota.

With financial pressures for regional health planning possible, by withholding Medicare funds (as suggested in a recent Brookings Institute report to the Department of Health and Welfare), it is not unreasonable to worry about becoming a medical satellite area when in truth we are well equipped with men and materials to function as a center. Fortunately the RMP has so far leaned over backwards to avoid putting Alaska in the satellite position.

However, as a small example of the problems that can arise by acceptance of federal (our own tax) funds from even a well intentioned third party, this may serve as a warning. With the flood of (medical care) funds presently available or expected, from often competing organizations as diverse as OEO and RMP, as well as over 1,200 other welfare agencies at last count, one is reminded that power corrupts, and absolute power corrupts absolutely. The present centralization of financing bodes ill for national freedoms.

Maybe the meek will soon rule the earth, but I'll wager they don't stay meek for long.

## JUNEAU

Dr. Robert F. Cavitt has taken over as director of Veterans Medical Services for Alaska. He plans to continue part-time in private medical practice.

Dr. Henry Akiyama reports that the October 11 and 12 Board of Medical Examiners meeting has recommended several significant changes in existing rules and regulations to be considered by the forthcoming legislature. These include the decision that U.S. Citizenship no longer be a requirement for licensure, and that the ECFMG examination be considered an adequate safeguard to assure that foreign graduates meet our medical standards, and that temporary licenses be made available more easily to a locum tenens. In addition the board adopted the national FLEX as a substitute for the individual state medical licensing examination. Alaska is one of the first dozen states to take this step. Also a review of the Basic Sciences requirement was made, although it appears that no firm position on this has yet been taken by the Board. There has been final clarification of the status of O.D.'s who have received later M.D.'s by various means.

The Board members and Dr. Akiyama are to be congratulated for taking this sleeping walrus by the tusks in the interests of better medical care for all Alaskans.



# U.S.P.H.S. REGULATIONS OR

## “ONCE A BENEFICIARY, ALWAYS A BENEFICIARY ....”

### PART 36 -- INDIAN HEALTH

NOTE: Regulations on Indian health were formerly codified as Parts 84 and 85 of Title 25.

#### Subpart A -- Scope and Definitions

Sec.

36.1 Purpose and effect.

36.2 Meaning of terms.

#### Subpart B -- Availability of Services to Individuals in Programs (Including Facilities Constructed or Supported With Tribal Funds) Operated for Indian Beneficiaries By the Public Health Service.

36.11 Services available.

36.12 Persons to whom services will be provided.

36.13 Charges to Indian beneficiaries for services provided in Public Health Service facilities or by Public Health Service personnel.

36.14 Nonbeneficiaries emergency care and treatment; charges.

#### Subpart C -- Contract Services

36.21 Availability of contract services.

AUTHORITY: 36.1 to 36.21 Issued under sec. 3, 68 Stat. 674; 42 U.S.C. 2003. Interpret or apply 42 Stat. 208, sec. 1, 68 Stat. 674; 25 U.S.C. 13, 42 U.S.C. 2001.

#### Subpart D -- Contagious and Infectious Diseases

##### TUBERCULOSIS

Sec.

36.30 Applicability.

36.31 Commitment of Indians afflicted with tuberculosis.

36.32 Retention of custody: utilization of law enforcement authorities.

36.33 Discharge of patients.

36.34 Transfer of patients.

AUTHORITY: 36.30 to 36.34 are issued under sec. 3, 68 Stat. 674; 42 Stat. 208; 42 U.S.C. 2003, 25 U.S.C. 13. Interpret or apply sec. 1, 38 Stat. 584; 25 U.S.C. 198.

#### SUBPART A -- SCOPE AND DEFINITIONS

36.1 Purpose and effect. (a) The regulations in this part establish the general principles to be followed in the discharge of this Department's responsibilities for continuation and improvement of the Indian health services. Officers and employees of the Department will be guided by these policies in exercising discretionary authority with respect to the matters covered.

(b) The Surgeon General of the Public Health Service is authorized to adopt, and from time to time revise or add, administrative instructions relating to methods or procedures appropriate to implementing these principles, or for their supplementation as to matters not covered, including instructions providing for the continuation or appropriate modification of practices and procedures previously observed in the provision of Indian health services in particular jurisdictions.

36.2 Meaning of terms. When used in this part, the term:

(a) "Indian health program" includes the Alaska Native Health Services.

(b) "Indian" includes Indians in the continental United States, and Indians, Aleuts and Eskimos in Alaska.

(c) "Jurisdiction" shall have the same geographical meaning as in Bureau of Indian Affairs usage.

(d) "Bureau of Indian Affairs" means the Bureau of Indian Affairs, Department of the Interior.

#### SUBPART B -- AVAILABILITY OF SERVICES TO INDIVIDUALS IN PROGRAMS (INCLUDING FACILITIES CONSTRUCTED OR SUP-

PORTED WITH TRIBAL FUNDS) OPERATED FOR INDIAN BENEFICIARIES BY THE PUBLIC HEALTH SERVICE

36.11 Services available. Within the limits of available funds, facilities, and personnel, the Public Health Service will make available, within the area served by the local facility, hospital and medical and dental care, including outpatient services, services of mobile clinics and public health nurses, and preventive care including immunizations and health examinations of special groups, such as school children.

36.12 Persons to whom services will be provided -- (a) In general. (1) Services will be made available, as medically indicated, to persons of Indian descent belonging to the Indian community served by the local facilities and program, and non-Indian wives of such persons.

(2) Generally, an individual may be regarded as within the scope of the Indian health and medical service program if he is regarded as an Indian by the community in which he lives as evidenced by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in tribal affairs, or other relevant factors in keeping with general Bureau of Indian Affairs practices in the jurisdiction.

(b) Doubtful cases. (1) In case of doubt as to whether an individual applying for care is within the scope of the program, the Medical Officer in Charge shall obtain from the appropriate Bureau of Indian Affairs officials in the jurisdiction information pertinent to his determination of the individual's continuing relationship to the Indian population group served by the local program.

(2) If the applicant's condition is such that immediate care and treatment are necessary, services shall be provided pending identification as an Indian beneficiary.

(c) Priorities when funds, facilities, or personnel are insufficient to provide the indicated volume of services. Priorities for care and treatment, as among individuals who are within the scope of the program, will be determined on the basis of relative medical need and access to other arrangements for obtaining the necessary care.

36.13 Charges to Indian beneficiaries for services provided in Public Health Service facilities or by Public Health Service personnel --

(a) In general. In order to make the most effective use of funds and facilities available for needed health and medical services, individual Indians who are clearly able to pay the costs of hospital care (and of other major items of service specified in instructions of the Surgeon General) will be encouraged to do so, and services may be conditioned upon payment in appropriate cases. No charge may be made for immunizations, health examination of school children or similar preventive services, or for the hospitalization of Indian patients for tuberculosis.

(b) Amount of charges. Payment may be requested in accordance with a schedule of charges established for the jurisdiction by the Area Medical Officer, but such charges may in no case exceed the cost of providing the service, as determined by the Surgeon General or in accordance with instructions issued by him.

(c) Circumstances under which payment may be requested: Authority of the Medical Officer in Charge. Whenever it is established to the satisfaction of the Medical Officer in Charge, from information available from the local Bureau of Indian Affairs officers or from other sources, that an Indian applying for care for himself or his family is able to meet the scheduled charge for the needed care without impairing his prospects for economic independence, he may be asked to pay the scheduled charge. Charges may be reduced in individual cases, or payment may be waived and needed services may nevertheless be provided if, in the judgment of the Medical Officer in Charge, the health objectives in the area served will be advanced thereby.

36.14 Nonbeneficiaries; emergency care and treatment charges.

(a) In case of emergency, as an act of humanity, nonbeneficiaries of the Service may be provided temporary care and treatment in hospitals and facilities of the Service which are operated for Indian beneficiaries.

(b) Persons referred to in paragraph (a) of this section who, as determined by the medical officer in charge, are able to defray the cost of their care and treatment shall be charged for such care and treatment at the following rates (which shall be deemed to constitute the entire charge in each instance): In the case of hospitalization, at the current interdepartmental reimbursable per diem rate as established by the Bureau of the Budget; and in the case of outpatient treatment, at rates established by the Surgeon General.

(Sec. 3, 68 Stat. 674; 42 U.S.C. 2003. Interpret or apply 42 Stat. 208, sec. 1, 68 Stat. 674, sec. 322(d), 58 Stat. 696, as amended, sec. 501, 65 Stat. 290; 25 U.S.C. 13, 42 U.S.C. 2001, 42 U.S.C. 249(d), 5 U.S.C. 140)

#### SUBPART C -- CONTRACT SERVICES

36.21 Availability of contract services. Availability of contract services to individual Indian beneficiaries will be governed by the terms of the contract.

#### SUBPART D -- CONTAGIOUS AND INFECTIOUS DISEASES

##### TUBERCULOSIS

###### 36.30 Applicability.

The regulations in this subpart relative to the commitment of Indians afflicted with tuberculosis apply only to Indian reservations where effective procedures for the commitment of persons afflicted with tuberculosis are not available under the laws of the State in which the reservation is located.

###### 36.31 Commitment of Indians afflicted with tuberculosis.

(a) Upon a determination by a tribal court or other Indian court of competent jurisdiction that an Indian within its jurisdiction has tuberculosis in a communicable form and that under applicable tribal law such Indian may be committed to a hospital or other place for medical treatment, the Area Medical Officer in Charge may, upon request of such court, certify that facilities and services of the Public Health Service are available to provide necessary medical treatment for the Indian if he determines in accordance with applicable instructions of the Division of Indian Health that the health of the afflicted Indian or that of other persons requires the isolation or quarantine of the Indian in a hospital or other place of treatment.

#### PAYMENT FOR SERVICES

##### 2-2.1 GENERAL

This section incorporates into the Indian Health Manual a decision of the General Counsel dated February 16, 1960, related to payments for services by Indians or Alaska Natives.

Your attention is invited to the following paragraph of the decision:

"... you are advised that the regulations do not require the Service to request payment for medical care in all cases where the Indian is able to pay."

##### MEMORANDUM

Dr. Aaron W. Christensen  
Deputy Chief, Division of Indian Health, BMS

February 16, 1960

Public Health Division  
Office of the General Counsel

Public Health Service--Indian health--Charges for care--Collection of charges

(PB 3200)

Your memorandum of January 13, 1960, requests our views on whether section 36.13 (a) of the PHS regulations which reads in part--

"... individual Indians who are clearly able to pay the costs of

hospital care (and of other major items of service specified in instructions of the Surgeon General) will be encouraged to do so ..."

merely establishes a "policy" regarding payment or imposes a legal requirement for the collection of such payment. From oral discussion we understand your question to embrace two elements:

1. Must Indians who are able to pay the costs of hospital care be charged?

2. Do such charges constitute debts due the United States subject to collection?

Assuming, for the purposes of this discussion, that the regulations could have validly provided for mandatory charges, it seems clear that no such requirement was established. Whether a charge is to be imposed in any individual case is specifically made a question for the judgment of the medical officer in charge who is authorized to exercise a wide range of discretion in the matter. Section 36.13 (c) of the regulations provides:

"(c) Circumstances under which payment may be requested. Authority of the Medical Officer in Charge. Whenever it is established to the satisfaction of the Medical Officer in Charge, from information available from the local Bureau of Indian Affairs or from other sources, that an Indian applying for care for himself or his family is able to meet the scheduled charge for the needed care without impairing his prospects for economic independence he may be asked to pay the scheduled charges ... (emphasis added.)

The permissive character of the authority granted the medical officer in charge by this language is emphasized by the mandatory direction in S 36.14 of the regulations that nonbeneficiaries found to be able to pay the cost of their care and treatment "shall be charged". (Emphasis added.)

This understanding of the regulations was reported to the Congress in the survey report "Health Services for American Indians" prepared by the Surgeon General in accordance with the request of the House Committee on Appropriations of the 84th Congress, 1st Session, in the following language:

"New regulations on fees provided similar leeway for local adaptation. In general, individuals who are 'clearly able to pay' for hospital care and specified other items of service 'will be encouraged to do so'. Like the old Bureau of Indian Affairs rules, however, the new rules do not require the collection of charges." (Emphasis added.)

Accordingly, you are advised that the regulations do not require the Service to request payment for medical care in all cases where the Indian is able to pay.

The second aspect of your question--whether, when a request for payment has been made, the "charge" so imposed is a debt due the United States subject to recovery by ordinary collection procedures, within the jurisdiction of the General Accounting Office, calls for a further consideration of the legal basis for this section of the regulations.

As you will recall, this provision follows the corresponding provision of the BIA regulations on charges to Indians, in effect at the time of transfer of the program to the Service (25 C.F.R. 84.8, 1949 ed.), which provided in part:

"Indians receiving medical, hospital, or dental services shall be expected to pay such fees, based upon the cost of services, as may hereafter be specified by the Commissioner of Indian Affairs ..."

This regulation was issued under the authority of a proviso to the Department of the Interior Appropriation Act of 1939 (52 Stat. 291, 312) which read:

"Provided further, that in the discretion of the Secretary of the



Interior and under such rules and regulations as may be prescribed by him, fees may be collected from Indians for medical, hospital, and dental service and any fees so collected shall be covered into the Treasury of the United States."

The purpose underlying the enactment of this proviso was stated by Samuel M. Dodd, Finance Officer of the Bureau of Indian Affairs:

"... Our purpose in submitting that item to the Budget was, first, to institute a means of bringing forcibly to the attention of the Indians now that sooner or later they are going to have to pay for some of their services, and get them in the habit of paying a portion of the expense of medical and hospital care where they are able to do so."

The quoted proviso was repeated in each subsequent Interior Department Appropriation Act through 1946. It was not repeated in the 1947 Act, or in any subsequent act although the regulation was left unchanged.

In our discussion with Bureau of Indian Affairs representatives prior to the transfer, they were unable to point to any legal authority for the continuation after 1946 of the policy expressed in the quoted regulation and we were unable to find any current express authority to charge fees for services rendered to Indians. We did indicate, however, in the cited memorandum, that the provisions of 5 U. S. C. 140 (expressing the sense of Congress that Federal services, etc., performed for any person "shall be self-sustaining to the full extent possible") supported the exercise of a fee charging authority by the Surgeon General. Title 5 U. S. C. 140, however, was not relied on to supply a legal base for the PHS regulation,

as is evidenced by the failure to cite it as authority for the section in question. Its applicability is, moreover, subject to question in the light of the basic responsibility of the Service for the health of Indians.

In considering this question further, we subsequently stated:

"(T)he present charging provisions (S 36.13) . . . were intended not to create a legal indebtedness on the part of the Indian. At the time of the transfer we were unable to find, and Interior was unable to inform us, of any specific authority for charging Indians for this medical care. The practice of charging had been adopted by Interior apparently as a part of a policy of encouraging Indians to be self-reliant and to pay for what they got when they could, and in the exercise of a general (if somewhat ill-defined) paternalistic authority. However, this apparently gave rise to a mass of so-called 'debts' which were uncollected and gave rise to many problems of 'settlement' involving GAO. The Service regulations carry a modified provision for charges designed to avoid some of these difficulties." (Emphasis added.)

It is still our view that a request for payment (which is all the regulation contemplates and authorizes) does not create a legal indebtedness on the part of the Indian and does not establish a debt due the United States subject to recovery.

In the light of the foregoing, you may wish to re-examine the administrative procedure for the implementation of S 36.13 to assure their conformance with that section.

Sidney Edelman

## FOR OUR CONFUSED READERS

### A "Clarification" from the U S PHS

Among other changes resulting from the reorganization of DHEW are several alterations in titles of its various subdivisions. Following in descending line of authority, are the Department and its major subdivisions, appropriate changes identified:

#### DEPARTMENT OF HEALTH, EDUCATION AND WELFARE (DHEW)

#### U. S. PUBLIC HEALTH SERVICE (USPHS)

#### INDIAN HEALTH SERVICE (IHS)

(Previously "Division of Indian Health: DIH)

#### ALASKA AREA NATIVE HEALTH SERVICE (AANHS)

(Previously "Alaska Native Health Area Office")

under whose direction are the 7 "PHS Alaska Native Hospitals" Anchorage, Barrow, Bethel, Kanakanak, Kotzebue, Mt. Edgecumbe, Tanana, St. Paul and St. George (Pribilofs) and a number of PHS Alaska Native Clinics and Health Centers located strategically throughout the State.

# EDITORIAL

With the proposed advent of the Title 19, Comprehensive Health Planning, OEO, RMP, and so forth, with the nationwide insistence on integrated health facilities, and with the pressure for coordination of local and state health programs to reduce cost, the entire USPHS presence in Alaska must be reassessed. All criticisms notwithstanding, the USPHS is an essential part of the native health picture in the village at this time. One can reasonably contend, however, that the USPHS should be phasing itself out of business as a segregated medical facility. This could be done effectively by more reasonable support of Native patient care in private medical facilities, and greater cooperation with state health programs.

Obviously a complete replacement of the USPHS in the Alaska health picture can only be gradual, and must involve both state and local health programs and facilities, with continuation of much of the financial subsidy now supporting the USPHS until the native is again largely self-sufficient.

Any adequate health planning must (1) eliminate race as the basis of separate medical facilities, (2) encourage local responsibility and control for maximal effectiveness, (3) take into account population trends, especially the migration of the young people from the villages, (4) provide epidemiological support to private medical care so that coordinated care of unusual local conditions is possible, (5) provide a major alcoholic study and care program (6) provide adequate funds to make private medical care of Native populations feasible and (7) coordinate all health related federal and state programs. In any case, no satisfactory solution is possible for these chronic problems for years to come, and the needs far outweigh the maximum financial capabilities of Alaska taxpayers.

In the meantime, construction of new USPHS facilities, and the persistence of established USPHS patterns of health care in the face of adequate alternate medical facilities (often developed despite USPHS competition and "patient drain") is an extravagance we can ill afford.

One example of an effective state-federal cooperative program is the continuing attack on tuberculosis in the villages. Here, however, the program could be specifically oriented at an identifiable public health problem having a known and practical medical solution.

The Alaska Native population has increased from 34,000 to 50,000 in the past 14 years. The unique Arctic and hereditary health problems of these people have been submerged by such contributions of the white

man as (1) new and unfamiliar infectious diseases (2) the new and inadequate high carbohydrate diet (3) an imbalance and general decline of game populations basic to the subsistence economy (4) over-population with inadequate permanent housing facilities for a normally mobile and scattered people and (5) welfare support. The latter tends to immobilize the population in a locale where no adequate means of subsistence remains, often with an unhealthful, non-educational and generally unsuitable environment.

The complex interaction of many factors causing alteration of the Native environment can be illustrated by one example of white man's effect on game populations: In an oversimplified form one can say that the vigorous bounty system and airplane hunting of wolves in the 1950's has contributed to dietary deficiencies among the Eskimo people.

With the wolf population down, sick caribou survived to spread brucellosis through the herd, rather than being eliminated by wolves (who do not get brucellosis). So now the Eskimo cannot eat uncooked caribou. Especially the raw bone marrow that he considered a delicacy, and which presumably contains some necessary nutrients, can no longer be eaten safely. So where does an Eskimo get the fresh milk, green leafy vegetables or what-have-you, to substitute for this dietary loss?

Permanent villages, often dependent on welfare, have serious crowding and sanitation health problems not critical to transient settlements. Sugar and candy bars have contributed to a serious problem of caries in childhood. The list could go on, but the point is, no matter how improvement is to be obtained, a huge outlay of money and trained people is needed to adequately integrate and educate the Native, both socially and medically. Any approach must include (1) education, (2) sanitation, (3) birth control, (4) an opportunity for decent housing, nutrition, medical care and employment.

Only then can the remarkable self-sufficiency of the people who owned this place before we came, be restored. It goes without saying that there is a great deal of talent available in the Native population to help them attain some of these goals, while in other fields such as education the entire concept is new and not necessarily desired by the recipient.

To encourage a dialogue on this important subject we have offered Dr. Lee equal space to continue this discussion in our next issue.



# AFTER TWO YEARS IN ALASKA WITH THE U.S.P.H.S.

By Robert R. Thompson, M.D.

The author wrote the following "open letter" on discharge from the U.S.P.H.S. in July, 1968 after one year in Tanana and one year in Mt. Edgecumbe. He believes that he speaks for most of the "two year men" and adds that he misses Alaska but not the U.S.P.H.S.

I have enjoyed my two years in Alaska as a doctor with the United States Public Health Service. During this time I have traveled over two-thirds of this state from Anaktuvak Pass to Yakutat and from Eagle to Angoon. During this same time I have talked intimately with many Indians and Eskimos or "native beneficiaries" as they are called by the government. As I leave Alaska for further medical training, I am sad for these people. Knowing that I may never return I feel obligated to leave them a farewell admonition in the form of this open letter.

The native people of Alaska undoubtedly owe much to the USPHS which has been in Alaska since 1954. There is no doubt that PHS has contributed much to the individual and community health of the native. They have had good help in the Alaska Department of Health in all but completely controlling tuberculosis. Certainly gone are the days when entire families spent years in Anchorage, Mt. Edgecumbe, or Tacoma. Certainly, too, because of PHS many women and infants have found their way through the process of child birth under aseptic conditions and many children have survived major illnesses as a result of at least semi-modern hospital care.

Now the question arises, how long can PHS continue to provide total medical care for a select group of Alaskans. It is the opinion of many that the USPHS has survived too long in Alaska for a number of reasons.

First of all, as a "system" of health care PHS violates a fundamental principle of American Medicine in that it does not give the patient or the physician the right to choose one another. This is the subtle ingredient often referred to as the "doctor-patient relationship". While it may seem vague to some, and a small price to pay for "free medicine", this "freedom to choose" is the cornerstone of preventive medicine - the very area in which PHS vows expertise. In fact the typical native in Alaska has been made overly concerned about his health without receiving a basic education in the fundamental principles of hygiene and nutrition.

The greatest loss of all to the native as a result of PHS cannot be measured tangibly and is not reflected

in the copious mortality and morbidity figures compiled by PHS. Yet the loss of human dignity is a very real event that will be measured and reflected in future generations of Alaska's first people. A native leader and PHS liaison officer recently criticized the humility of the native that arises from a sense of gratitude to the PHS. Why, reasoned he, should a native be embarrassed or ashamed to accept services which are rightly his as a result of obligatory Federal promises. While this is not an unreasonable position it shows a lack of understanding of the deficiencies inherent in a forced doctor-patient relationship where both doctor and patient are captive of a third party.

Secondly, apart from robbing the native of his self-esteem and giving him no choice in the selection of his physician there is a very practical reason why an alternative to PHS should be sought. It is simply wasteful and inefficient as a result of being dependent upon the budgetary whims and arbitrary emphasis on various health programs in Washington; This is so obvious and can be borne out by so many specific examples as to be virtually incontestable. The administrator of a community hospital in Alaska recently estimated that the cost of hospitalizing the average native was four times that of a non-native. The cost could be legitimately accountable to other health services such as nutritional guidance, mental health, and sanitation but presently there either are no services available in these areas or those available are woefully ineffectual. Because of poor planning or none at all, many high priority health needs go unmet while critical funds are diverted to create new administrative jobs - and the tail not only wags the dog but the whole dog team as well!

What then is the alternative, if any, to the Public Health Service in Alaska? Those of us who have lived and worked with Alaskans refuse to believe that the people of this state cannot design a plan to meet the health needs of all her people. At the very least, plans should be made to diminish the role of the Federal government rather than enlarge it, and the State Department of Health as well as private practitioners of medicine should seek an ever more active role in caring for the native, until the term "beneficiary" no longer connotes second class citizenry with respect to medical care. The native likewise should insist through his brotherhood representatives and state congressmen on the right to have a voice in the meeting of his own

physical and environmental health needs. The State Department of Health which has heretofore assumed a passive role in caring for the natives should seek autonomous health programs subsidized by the federal benefactors rather than dominated by them. State health officials and private practitioners should together insist on the strengthening of federally funded contracts with private medicine, using these means maximally as a desirable alternative to PHS.

All of these groups - natives, doctors, state health officials - as well as all Alaskan citizens should probably begin thinking in terms of a medical school of the State's own. This does not seem to be an un-

reasonable goal for a state with so large a growth potential and such unique health problems, many of which require a unified approach. Admittedly this is long range thinking but the need will someday be imminent if it is not already and it is this kind of planning that will ultimately be necessary if Alaskan "statehood" is to be fully realized.

Those who are willing to solve Alaska's problems in Alaska in the field of health as in other areas will find the rewards plentiful. The strength of Alaskan medicine must likewise come from within and not from further proliferation of a benevolent federal government. The challenge is here and the time is now.

## BOOK REVIEW SECTION

By Frederick J. Hillman, M.D.

**NOTICE OF BOOKS RECEIVED:** Books will be reviewed as time and interest permit. This acknowledgement of receipt must be regarded as sufficient return for the courtesy of the sender.

A Doctor's Approach to Sensible Dieting and Weight Control. By Paul G. Neimark; in consultation with Eugene Scheimann, M.D. 113 pp., illustrated. Chicago: Budlong Press Company, 1968.

A Doctor Discusses Narcotics and Drug Addiction. By Louise Relin; in consultation with Robert L. Sharoff, M.D. 90 pp., illustrated. Chicago: Budlong Press Company, 1968.

Drugs of Choice 1968-1969. Edited by Walter Modell, M.D. 907 pp., illustrated. St. Louis: C. V. Mosby Company, 1967.

Medical Licensing in America, 1650-1965. By Richard Harrison Shryock. 124 pp., Baltimore: The Johns Hopkins Press, 1967.

Medical Pharmacology Principles and Concepts. Fourth Edition. By Andres Goth, M.D. 749 pp., illustrated. St. Louis: The C. V. Mosby Company, 1968.

Modern Treatment, Volume 5 #2 Treatment of Parkinson's Disease and Allied Disorders. Guest Editor Warren V. Huber, M.D. Treatment of Acquired Hemorrhagic Disorders. Guest Editor Oscar D. Ratnoff, M.D. 219 pp. New York: Hoeber Medical Division of Harper & Row, Publishers, Incorporated, 1968.

Modern Treatment, Volume 5 #3 Treatment of Gallbladder Disease, Guest Editor James B. Carey, Jr., M.D., Ph.D. Treatment of Menopausal Problems. Guest Editor Eugene J. Cohen, M.D. 131 pp. Illustrated. New York: Hoeber Medical Division of Harper & Row, Publishers, Incorporated, 1968.

Modern Treatment, Volume 5 #4 Treatment of Fluid and Electrolyte Im-

balance. Guest Editor David D. Thompson, M.D. Special Article, Current Treatment of Clinical Tetanus. By Norman A. Christensen, M.D. and Deloran L. Thurber, M.D. 115 pp., illustrated. New York: Hoeber Medical Division of Harper & Row, Publishers, Incorporated, 1968.

P-Q-R-S-T; A Guide to Electrocardiogram Interpretation. Fifth edition. By Joseph E. F. Riseman, M.D. 321 pp., illustrated. New York: The MacMillan Company, 1968.

Strabismus in Childhood. Fourth edition. By Herbert M. Katzin, M.D. and Geraldine Wilson, R.N. 83 pp., illustrated. St. Louis: The C. V. Mosby Company, 1968.

The Heart and The Law. By Saggall & Reed. New York: The MacMillan Company, 1968.

Synopsis of Pathology. Seventh edition. By W.A.D. Anderson, M.D. and Thomas M. Scotti, M.D. 957 pp., illustrated. Saint Louis: The C. V. Mosby Company, 1968.

Obstetric Forceps. By Leonard E. Laufe, M.D. 154 pp., illustrated. New York: Hoeber Medical Division, Harper & Row, Publishers, 1968.

Handbook of Pediatric Medical Emergencies. Fourth edition. By Charles Varga, M.D. 694 pp. illustrated. Saint Louis: The C. V. Mosby Company, 1968.

Practical Psychiatry for the Internist. By Douglas Goldman, M.D. and George A. Ulett, M.D. 168 pp. Saint Louis: The C. V. Mosby Company, 1968.

Questions and Answers on Contact Lens Practice. By Jack Hartstein, M.D. 199 pp., illustrated. Saint Louis: The C. V. Mosby Company, 1968.

1968 Pediatric Therapy 1969. Third edition. Edited by Harry R. Shirley. 1294 pp., illustrated. Saint Louis: The C. V. Mosby Company, 1968.

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## CLASSIFIED AD SECTION

This classified ad section is provided to give members an opportunity to make known their needs for medical and paramedical personnel. Please address all correspondence regarding insertions to: Robert G. Ogden, Executive Secretary, Alaska State Medical Association, 519 W. 8th Avenue, Anchorage, Alaska 99501.

**SOLO IN ANCHORAGE** - Immediate opening for a physician interested in a solo practice in Anchorage, Alaska. Good downtown location, reasonable rent, offices and equipment all set up. See at the Medical-Dental Building, 140 East 5th Avenue, or telephone H.A. Nahorney, DMD, MSD at 272-7033.

**ANCHORAGE MEDICAL AND SURGICAL CLINIC** announces openings for Internist, General Practitioner, and Orthopedic Surgeon. Would like young men under 40 with military obligations fulfilled. If interested, contact: Howard G. Romig, M.D., 718 K Street, Anchorage, Alaska 99501.

**INTERNIST:** The Tanana Valley Medical Clinic has an opening for an internist. Would like young man under 40 with military obligations fulfilled. If interested, please contact Mr. Al Seliger, Business Manager, 1007 Noble Street, Fairbanks, Alaska.

**THE FAIRBANKS MEDICAL AND SURGICAL CLINIC** announces opening for general practitioners, internists and pediatricians. For particulars please contact the Business Manager, Fairbanks Medical and Surgical Clinic, Box 1330, Fairbanks, Alaska.

**GENERAL PRACTITIONER WANTED -- ASSOCIATE POSITION:** this opening includes plans for a possible future partnership. New office with all facilities available. Contact Royce H. Morgan, M.D., 1844 W. Northern Lights Blvd., Anchorage, Alaska 99503.

**POSITION AVAILABLE** December 1st for Laboratory Technician preferably with X-ray experience. Salary open. Write Doctor's Clinic, 2nd & Franklin, Juneau, Alaska.

**DR. PAUL ISAAK** informs us that he has a number of requests from Medical Students who wish to serve a General Practice Preceptorship in Alaska. He has offered to co-ordinate such student requests with Alaska physicians. Medical Students and interested Alaska physicians should contact Paul Isaak, M.D., Box 569, Soldotna, Alaska 99669.

**5-YEAR BOUND VOLUMES OF ALASKA MEDICINE---** Alaska Medicine printer, Ken Wray's Print Shop, Inc., can make available through the Alaska State Medical Association office, 519 W. 8th Avenue, Anchorage, 277-6891, bound volumes of Alaska Medicine (Vol. 6, No. 1, through Vol. 10, No. 4). Cost \$10.00 (physician furnishes magazines). Orders must be placed through the A.S.M.A. office.

**\$25,000.00 to \$32,500.00 NET GUARANTEED** first year PLUS many fringe benefits depending upon experience and qualifications. Need both general surgeon and internist (Board certified or Board eligible) who would also do some general practice and a small amount of industrial medicine (10-20 minutes/day) or GP interested or experienced in surgery. These openings are available immediately or would sign contract if finishing residency in June. Partnership available second year or sooner with absolutely no investment necessary for eventual full partnership. Practice net income quite large because of high collection rate and exceedingly low overhead. Over 95% of patients are fully insured for any and all services rendered. All of the above is possible because of unique association between clinic and three large industries in town employing a total of 2,100. Town of 3,500 economically unsurpassed in all aspects located in beautiful NE Minnesota's Superior National Forest. Large unopposed clinic fully equipped in all aspects. Staff consists of 4 X-ray techs, 1 lab tech, 1 RN and 3 secretaries. Good housing for rent or purchase. Equal vacation (6 weeks) and rotating night and weekend call. Fifteen minutes from modern hospital with radiology and pathology consultation. Excellent school system and most churches represented. Excellent hunting - fishing - golfing - camping - boating - skiing - fresh air. All replies confidential. Call after 6 p.m. or write with particulars and resume of background. T. C. Leach, M.D., Babbitt, Minnesota 55706. (218)-827-6830.

### ALASKA DEPARTMENT OF HEALTH AND WELFARE

#### 1. Regional Health Officer, Fairbanks

Duties: Directs all state public health activities in large region.

Requirements: M.D. degree plus M.P.H. or 26 semester hours in Public Health and 2 years of practice of medicine or public health, and eligible for license. Salary: \$20,748.00 to \$21,576.00 depending upon qualifications.

#### 2. Chief, Child Health Branch, Juneau

Duties: Plans and coordinates Maternal and Child Health and Crippled Children's Services programs.

Requirements: M.P.H. or 2 years graduate training in medical specialty appropriate to position and 2 years practice in specialty, or 4 years experience in public health medicine, and eligible for license. Salary: \$19,380.00 to \$22,572.00 depending upon qualifications.

Contact Donald Freedman, M.D., M.P.H.

Director, Division of Public Health

Pouch H

Juneau, Alaska 99801

**DOCTOR NEEDED.** General physician to work in newly constructed \$100,000 Health Center serving town of 670 population. Good year round payroll. For further information write City Clerk, City of Skagway, P.O. Box 415, Skagway, Alaska.

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